

**MAKING ETHICAL MEDICAL DECISIONS:
A MODEL OF CLINICAL ETHICS
AND COVENANTAL THEOLOGY**

**A Professional Project
Presented to
the Faculty of the
School of Theology at Claremont**

**In Partial Fulfillment
of the Requirements for the Degree
Doctor of Ministry**

**by
Barry Bruce Heath**

May 1994

Quotations from Principles of Biomedical Ethics by Tom L. Beauchamp and James F. Childress, © Copyright, Oxford University Press, 1989. Used by permission.

Quotations from Clinical Ethics, 2nd ed., by Albert R. Jonsen, Mark Siegler, and William J. Winslade, © Copyright, McGraw-Hill, Inc., 1986. Used by permission.

© 1994

Barry Bruce Heath

ALL RIGHTS RESERVED

This professional project, completed by

BARRY B. HEATH,
*has been presented to and accepted by the Faculty
of the School of Theology at Claremont in partial
fulfillment of the requirements for the degree of*

DOCTOR OF MINISTRY

Faculty Committee

Alan D. Rhodes

David R. Johnson

April 29, 1994
Date

Virginia Luchini
Dean

ABSTRACT

Making Ethical Medical Decisions: A Model of Clinical Ethics and Covenantal Theology

Barry Bruce Heath

This project describes an ethical decision-making process for medical decisions using the tools of clinical ethics and covenantal theology. The problem addressed is that medical options are available today that offer choices but there is no definitive answer to what is the right or wrong choice. Complicating this problem is the fact that the diversity of contemporary society has not given rise to a generally accepted, recognized, and practiced system of moral decision making. Even within the Christian community there is no general agreement on the moral choices to be made in contemporary medical decisions. Adding to the dynamics of the problem is the emphasis on the autonomy of the individual which results in more power in medical decisions given to an ill-prepared patient and, shrinking health care resources which have forced medical choices to admit that all that can be done perhaps should not be done.

To respond to this contemporary medical ethical situation, this project takes the clinical ethical decision making model developed by Drs. Albert Jonsen, Mark Siegler, and William Winslade and revises it to be more inclusive of factors of faith, theology, and values. This revision comes from the perspective of a covenantal theology and ethic that begins with the work of H. Richard Niebuhr and James B. Nelson.

The methodology of this project is to raise a new perspective and added questions developed from a covenantal theology and ethic to each of the four main areas of the medical ethical decision developed by Jonsen and colleagues. In addition, foundational work in the principles of bioethics done by Tom Beauchamp and James Childress is presented along with the work of other contemporary ethicists. The result is a challenge to all involved to be more inclusive of values and covenantal relationships in medical decisions. Adding this perspective makes medical decisions more complete and such a process of questioning gives a model that persons can use even when their theologies, values and moral systems differ.

ACKNOWLEDGEMENTS

The author wishes to gratefully acknowledge the encouragement and counsel of the chair of my doctoral committee Dr. Dan Rhoades for his insight, foresight and faith in this project since its inception. Thanks also to Dr. David Larson, member of the committee for his perceptive questions and guidance which helped keep the author focused on an achievable end! Also to be thanked is Elaine Walker for her gentle and precise guidance in the editing of the final project. Finally, I am sincerely grateful to the members, leaders and staff of Westminster Presbyterian Church, Salem, Oregon. It was their encouragement and support, given as their gift to me and as their part of this endeavor, which made the completion of this project possible while I continued to serve as their pastor.

Table of Contents

Chapter	Page
Introduction	1
The Problem	1
The Approach	2
Scope and Limitations	3
Methodology	4
1. Bioethical Decision Making	7
Introduction	7
The Birth of Bioethics	7
The Philosophical Basis of Medical Ethics	14
Principles of Biomedical Ethics	16
A Critique of Principlism	19
The Four Principles	22
The Casuist Approach	23
Ethics and Clinical Decisions	27
2. Covenantal Ethics	31
Introduction	31
History and Contemporary Context.	32
Covenantal Ethics: A Definition	36
Creation and Creativity	38
The Good vs. Meaning	38
Creation.	40
Creativity	43
Revelation and History.	46
Identity.	50
A Theology of the Body.	50
Community	55
Responsibility	60
Niebuhr's Imagery	60
The Triangle of Responsibility.	64
The "Fitting Response".	65
Transformation.	66
Implications for Dialogue with Bioethics	69
Strategies for Moral Decision Making.	70
Community Involvement.	72

Authority	74
A Radical Definition of "Health"	75
Conclusion	77
3. Medical Indications and Covenantal Values	78
Introduction	78
Medical Indications in Clinical Ethics	78
The Principle of Beneficence	81
Medical Futility	86
A Covenantal Approach to Medical Indications	91
Values and Clinical Decisions	91
The Definition of Disease, Illness and Health	94
A Question of Meaning, Not Just Treatment	94
A Question of Time	96
Authority	97
Responsibility	98
The Role and Authority of the Physician	99
A Covenantal Ethics Approach to Futility	100
A Case Study - Hilga Wangle.	103
The Case	103
Commentary	104
Summary	107
4. Autonomy and Covenantal Relationships	108
Introduction	108
Autonomy and Clinical Ethics.	108
Competence and Capacity to Choose	109
Informed Consent	110
Refusal of Treatment.	111
Summary	113
The Ethical Principle of Autonomy	113
Historical Development	113
Adequate Autonomy	117
The Tests of Adequate Autonomy	117
Autonomy and Authority.	121
Autonomy and Community	125
Relationship of the Autonomous Individual to Community	127
The Relationship of the Community to the Individual	129
The Problem of Paternalism	131
Autonomy and Covenantal Theology	136
Greek and Pauline Autonomy	138
The Meaning of Freedom	139
Decision Making in the Covenant Community	141

A Case Study: Autonomy and Faith Healing in Childhood Leukemia	144
The Case	144
Commentary	145
Conclusion	149
5. Quality of Life and Covenantal Personhood	151
Introduction	151
Quality of Life in Clinical Ethics	151
Regarding the Termination of Life Support.	153
Regarding Euthanasia	155
The Principle of Nonmaleficence	156
The Principle of Double Effect and Nonmaleficence	158
Killing and Letting Die -- Withholding and Withdrawing	159
Optional, Obligatory and Wrong Forms of Treatment	161
Quality of Life Judgments	162
Quality of Life as a Measurable Factor	163
Quality-Adjusted Life-Years.	164
Who Decides Quality of Life?	168
Ambiguities Are Important	171
Quality of Life and Covenantal Ethics	171
Sanctity of Life and Quality of Life	171
The "Value" of Death.	174
Personhood	175
Quality -- A Community Concept	178
A Response to Ramsey	180
A Case Presentation -- Euthanasia	181
The Case	181
Commentary	183
Conclusion	189
6. Contextual Factors and Covenantal Justice	191
Introduction	191
Contextual Factors in Clinical Ethics.	191
Factors for Consideration	192
Clinical Judgment and Health Policy	193
Role of Interested Persons	194
Cost of Care.	195
Allocation of Scarce Resources.	196
The Principle of Justice	199
Justice and Covenantal Ethics	207
Justice is Relationship	207
The Patient is a Population	213
Rationing	218

A Case Study -- Kenny G	221
The Case	221
Commentary	224
Conclusion	228
Bibliography.	229

Introduction

The Problem

Technology today has made medical options available that are beyond clear ethical choices of right or wrong. The medical profession, correctly and understandably, is not willing to make these decisions for the public. The courts, in turn, have clearly emphasized in several decisions that the autonomy of the patient in making ethical decisions and choices is to be respected and upheld in most cases. This means that the patient and/or patient's family or surrogate is called upon to make medical ethical decisions that they are often ill equipped to make.

This emphasis on autonomy also means that the foundational question of ethical decision making has changed from what is best for me *and* others to what is best for *me*. And along with the change in the questions being asked in ethical decision making, there have also been changes in the tools and methods used to answer ethical questions. Today, there is an absence of a clear moral system by which decisions are made. Concepts such as right and wrong are being replaced by goals to seek what is most comfortable or best or what works. The way to these goals seems to be guided more by the context of the decision than by any philosophical or theological base or method.

As persons begin to exert more and more autonomy in their moral realm, the relationships of those involved in the ethical decision are also

changed. Today, these relationships are built more on contract than on covenant. One result of this is that in the individual rather than in the community is where authority is placed.

Many Christians in today's morass of medical ethical decisions also are ill-equipped to make ethical decisions. Christians who are not prone to a biblical literalist position either neglect the tools of their theology and faith tradition, are uncertain how to apply them, or find the answers of their theology and faith tradition to be inconclusive or inapplicable. This does not need to be the case.

The Approach

This project endeavors to combine a clinical ethics decision making model with a Christian covenantal theology in an attempt to provide a framework for making medical ethical decisions with the tools of faith and philosophical ethics in dialogue. To do this, the work in clinical ethics done by Drs. Albert Jonsen, Mark Siegler, and William Winslade is adapted and added to by covenantal theology and covenantal ethics. The basic foundation for this theology and ethics is the work done by H. Richard Niebuhr and James B. Nelson. What is proposed here is a reworking of the clinical ethics model of decision making by evaluating, with a covenantal theology, the data collected in each of the areas suggested by the clinical ethics model. It is the conviction of this project that by adding this theological dialogue to the clinical ethics model a more informed and complete ethical decision can be

reached, one that takes into consideration theology as well as clinical data. Further, it is hoped that the process used here can serve as an encouragement for medical ethical decision making using other theological approaches.

Scope and Limitations

This project uses the Clinical Ethics approach developed by Jonsen and colleagues. Even though there are other models, this model has the advantage of organizing medical ethical decisions into a methodology that requires:

1. Considering essential ethical principles in such a way so as to prevent one setting aside certain principles in favor of others or making one ethical principle always of greater weight than another.
2. Considering four areas of the clinical data in such a way as to ensure the inclusion of all relevant data without predefining what is important and what is not.
3. Cross referencing of decisions made in each area so that a decision reached based on the data in one area is not the final decision until all of the relevant data have been compiled and compared.

The model is deficient, however, in that it only includes theological questions and data in one area rather than all areas. This study advocates raising theological issues and perspective in each area and encourages the

dialogue of theology and ethical principles in order to make a more complete decision.

For the theological framework, the work of H. Richard Niebuhr, particularly in the area of responsibility and relationships (of God to creation and individual to God and neighbor) provides a challenge to clinical ethics to enter into a dialogue with theology, to be changed by theology and a challenge to one's theological position to be expanded and perhaps changed by the clinical ethical decision. Niebuhr is also helpful in thinking through the issues of authority and the ties of covenant community.

The work of James B. Nelson is also foundational to the theological framework. His work is particularly helpful in forming a theology of the body which argues against the dichotomy of body and spirit and, therefore, will not allow a medical decision to separate the *meaning* of the decision from the physical implications. Nelson is also helpful in challenging the authority of the clinical data in decision making as well as the supremacy of the ethical principle of autonomy.

Methodology

Chapter 1 describes the history of medical ethical decision making, the philosophical basis of bioethics, the ethical principles used in the clinical ethics model, and the method of casuistry which is used by Jonsen et. al., and is also an important tool to test the validity of this approach to bioethical decision making.

Chapter 2 is an exploration of the foundations of covenantal theology. The basic work relevant to this study of Niebuhr and Nelson is presented here. Key understandings of covenant, responsibility, and body are defined that will be the starting place of a new way of looking at the ethical decision and essential for the defining of the relevant ethical issues.

Chapter 3 examines the medical indications area of clinical ethics and the importance of being aware of and taking into consideration the values involved in the determination and the interpretation of the clinical data. The bioethical principle discussed in this chapter is the principle of beneficence. To examine the importance of considering values in the decision making process in this area, a case study involving the determination of futility is considered.

Chapter 4 explores the area of patient preferences and the place of such preferences in the ethical decision. The principle considered here is that of autonomy. In this chapter autonomy is challenged by an understanding of responsibility in a covenantal ethic. A case study involving a conflict between a patient's preferences based on their faith and a judgment based on medical indications illustrates one way covenantal theology can raise questions and issues which require a new look at an ethical dilemma.

Chapter 5 considers the area of quality of life determinations and the clinical ethical decision. Measures used to determine quality of life are evaluated and the ethical principle of nonmaleficence is described as it helps

in applying quality of life determinations to the ethical decision. In this chapter the definition of quality is challenged from a covenantal theological perspective and this is then applied to a case study of euthanasia.

Chapter 6 examines the area of Clinical Ethics known as contextual factors. This area includes the consideration of a diversity of information. The ethical principle of justice is often of most importance in this area and thus, it is explored as well. A case study dealing with the rationing of health care resources enables a covenantal theological approach to be used and illustrated.

CHAPTER 1

Bioethical Decision Making

Introduction

This chapter reviews the relevant foundations of contemporary decision making in bioethics. First, the history of bioethical decision making is examined. This history will establish the beginning issues and questions that shape the contemporary experience. Second, the philosophical basis of bioethics is described. Third, the principles of bioethical decision making as defined by Tom Beauchamp and James Childress is summarized. Their work is especially important for the purposes of this study as the principles they define are foundational to the design of clinical ethics developed by Jonsen, Siegler, and Winslade. Fourth, the method of casuistry is presented and examined. This method is not only used by Jonsen et al., but will be a method used to examine the application of the theological perspective of this study. Finally, the clinical ethical decision making model of Jonsen and colleagues is presented to orient the reader for the detailed presentation in succeeding chapters.

The Birth of Bioethics

At the Birth of Bioethics Seminar held at the University of Washington, the date of 1962 was given as the beginning of bioethics. This was the year a review committee was established composed of lay persons and medical

personnel to decide who, out of all applicants, would qualify to receive life-saving but costly and limited in availability renal dialysis.

On March 9, 1960, Dr. Belding Scribner administered dialysis to his patient Clyde Shields using a shunt that Scribner had developed that could be left in the patient's vein and artery, making it possible to perform the dialysis as often as necessary. Although the technique of dialysis had been developed in the 1940s, it could not be used repeatedly on the same patient until the development of the shunt. With the shunt, however, came questions and issues that inaugurated the modern era of bioethics and that remain among the perplexing issues in contemporary discussions. The questions for the selection committee were who should receive the limited resources of medical technology and how shall this and similar ethical issues be decided, by whom, and on what criteria?

Although there have been other events that could compete successfully as the birth place of contemporary bioethics, certainly the review committee set up at the University of Washington marks an event that directly relates to the interests of this study. The field of medical ethics, however, has roots much further back in time, in the field of ancient mythology¹

¹For much of the information contained here I am indebted to a paper delivered by Dr. Albert Jonsen, "Ethics and Clinical Decisions," and my notes from that lecture delivered at the 4th Annual Summer Seminar in Health Care Ethics, held at the University of Washington Medical School, 5 Aug. 1991.

In Greek mythology there is a god called Asklepios. This son of Apollo by the human woman Koronis was born by a procedure now known as cesarean. The child was raised by a brilliant physician known as Chiron, who taught him the arts of medicine.

Asklepios became quite skilled himself but when he healed someone that the gods had condemned to death, he himself was killed by Zeus. Asklepios had gone beyond the limits prescribed for the use of his skills and thus his story sets the stage in ancient mythology for the questions of limits that are very much on center stage of bioethical debates today.

The Hippocratic tradition is another milestone in medical ethics. This tradition dates from the fifth century B.C. Hippocrates was a Greek physician. He and his disciples left a large collection of literature that outlined their scientific work and with it some moral directives. Several of these maxims were collected into what became known as "The Hippocratic Oath," an oath that was used for eighteen centuries to guide and set the work and ethical standards for physicians as they learned and practiced medicine. One of the maxims declared, "I will act to benefit my patient and do no harm or injustice," thus setting down an early oath for medical practitioners with the ethical principles of beneficence and nonmaleficence. The oath highlighted other aspects of medical practice including respect for those who taught the arts of medicine, a treatment of the body of knowledge of medical practice as a sacred trust with the physician swearing to teach this art only

to specific others who are a part of the fraternity of practice, and an emphasis on the competence of the physician. This last principle of competence places the physician in a position of holding the key to healing. Disease was seen as something that came not from the gods, but as a mistake of nature and, therefore, was open to cure through the healing skill of the physician. This pre-scientific understanding of disease placed considerable authority with the physician. Later, when scientific knowledge and technology were added to medical practice, the authority of the physician increased and the stage was set for the contemporary tension between paternalism and patient autonomy.

The realms of medicine and religion have also been intermixed in the history of bioethics. In Jewish and Christian theology, for example, those who heal are understood as being instruments of God and the patient is viewed as one who is to be served even at a cost to oneself (see Luke 10:30-37, the parable of the Good Samaritan). There has also been an adaptation of the Hippocratic Oath so that a Christian may swear it. In this adaptation the physician swears "In whatsoever houses I enter, I will do so to help the sick," and asks God's blessing: "may God be my helper in my life and art."²

²The oath titled "The Oath According to Hippocrates In So Far as a Christian May Swear It," is from W. H. S. Jones, The Doctors Oath: An Essay in the History of Medicine (New York: Cambridge University Press, 1924), 23-25 as quoted in Allen Verhey, "The Doctors Oath -- and a Christian Swearing It, in On Moral Medicine, eds. Stephen Lammers and Allen Verhey (Grand Rapids: Eerdmans, 1987), 72.

Thus, there is an emphasis on the skill and compassion of the physician to heal technologically and serve the patient but also to practice their art as an instrument of God. In this combination of medicine and religion all aspects of the practice of one's medical skills have a theological and a moral dimension as well as a physical healing one.

With the eighteenth century came the opening of the modern scientific age and with it came the understanding of medicine as a "profession" set apart. In the opening years of the nineteenth century Percival's statement regarding the physician's status became a part of the American Medical Association Code:

Physicians should minister to the sick with due impression of the importance of their office, reflecting that the ease, health and lives of their patients depend on their skill, attention and fidelity. They should study so to unite tenderness with steadiness, and competence with authority as to inspire the minds of their patients with gratitude, respect and confidence. [Percival, 1804; AMA 1847-1912]³

Note how almost condescending the art of healing becomes. One of the stresses of this modern era's approach to medicine is that as more and more importance is placed on the competence and skill of the physician and, as in this century, technology becomes more and more the tool of medicine, the physician gets further removed from patient care and becomes instead a manipulator of scientific technology. Concomitantly, the patient becomes less

³Quoted in the manual from the 4th Annual Summer Seminar in Health Care Ethics, University of Washington, 5-10 August 1991, 1-1.

and less a person to be served and more and more a subject to be treated. As competence and skill become increasingly important "the so-called humanistic virtues are treated as ancillary to the central core of competence, which lies in mastery of data and method."⁴

In the beginning of the twentieth century, Dr. Richard Cabot, professor of medicine and holder of the Harvard chair in social ethics developed an "ethics of competence" which began to recapture a stress on serving the individual patient as well as practicing technical skill. This ethics of competence served well as a way of combining the old Hippocratic maxims with the growing knowledge of modern science for the first half of the century. What Cabot could not see, however, from the beginning of the century was the problem of an excess of competence that would become a bioethical problem of the later half of this century. Today competence can be overused or used in the wrong time in the wrong place for the wrong purpose.

With the last two decades new ethical dilemmas have come to the forefront of the practice of medicine. Jonsen notes a paradigm shift for modern bioethics from a patient-based to a population-based model of medical practice. This has brought with it new bioethical problems.

To be sure, medicine has always faced the problem of disease in populations. Containment of epidemic disease and prevention by immunization belong to the old medicine. But the new epidemic of

⁴ Albert R. Jonsen, The New Medicine and the Old Ethics (Cambridge: Harvard University Press, 1990), 25.

AIDS has recalled with horrifying vividness the links between individual illness and the health and disease, behavior, knowledge, and values of populations. The discomfort we feel over the conflict between protecting the uninfected and respecting the rights of the infected is a manifestation of our strong commitment to a patient-centered ethic of competence as it faces our looming awareness of a population of infected persons dwelling in a population of uninfected persons. In this vision, the patient-centered ethic is threatened.⁵

This reality for modern medicine presents a challenge to our visioning and defining of the task. More and more, medicine will become a part of the social sciences as well as the clinical sciences. As a population-centered approach is taken, the individual patient is not lost but is seen as a part of an interdependent system with each part affecting the others and with one's past (a population represented in one's genetic make-up) influencing one's present and future. In addition, as technology continues to expand, choices and options for one's present and future medical well-being also expand. Yet, these choices are never made in isolation. Many medical choices affect others. Again Jonsen expresses it well.

The intrinsic ethical limits to competence, based on undesirability of care from the patient's viewpoint or futility of care from the physician's, are no longer sufficient. Even if a particular patient should judge medical attention to be undesirable, we know that others in the relevant population may be affected by that refusal or need information or therapy that depends on the patient's decision. Some of those others may not be identifiable or even currently extant: the fetus of a pregnant woman who rejects the abortion option despite an inheritable disorder, or the son of a man with

⁵ Jonsen, New Medicine and the Old Ethics, 32.

Huntington's disease who declines testing and goes on to procreate.⁶
Competence now extends beyond the care of the presenting patient.

This new challenge for medicine requires increasingly a new model for bioethical decision making -- a covenantal model perhaps that incorporates a population-centered medical approach with a respect for the serving of the individual patient.

Contemporary bioethical problems may be phrased in different ways and the variety of expressions may help define new approaches to decision making. The challenge may not so much be from having new and more difficult problems but from not having a foundational ethic to deal with them. It is not so much that technology has "outdistanced our ethics, if anything, it became a substitute for having an ethical consensus."⁷ A new approach to thinking through ethical questions and arriving at ethical decisions is needed.

The Philosophical Basis of Medical Ethics

The model of bioethical decision making developed by Jonsen, Siegler and Winslade finds its philosophical base in the work on principles done by Dr. Tom Beauchamp and James Childress. Before examining this particular

⁶ Jonsen, New Medicine and the Old Ethics, 34-35.

⁷ David C. Blake, "The Hospital Ethics Committee: Health Care's Moral Conscience or White Elephant?" Hastings Center Report, January/February 1992, 7.

philosophical base, it will be helpful to place this approach within the whole scheme of philosophical ethics.

Approaches to ethics can be labeled normative and non-normative.⁸

Non-normative approaches are descriptive. They do not take moral stands as to what one should do, but describe moral positions. For example, a non-normative approach would say "cheating is not allowed" as opposed to "one should not cheat." An example of non-normative ethics is metaphysics which describes or evaluates ethical terms and methods. Again, there is no attempt to prescribe certain actions.

Normative approaches, by contrast, take moral stands. A general normative ethic seeks to answer the question "which action-guides are worthy of moral acceptance and for what reason?"⁹ Examples of such general normative ethics are teleological theories such as utilitarianism or perfectionism and deontological theories such as Kantian ethics and Divine Will theory. These general normative ethical theories seek to formulate a system of principles and rules which can guide behavior. They do not define

⁸Material presented here is, in part, based on notes taken by the writer from a paper delivered by Dr. Nancy S. Jecker, "The Contribution of Philosophical Ethics," at the 4th Annual Summer Seminar in Health Care Ethics held at the University of Washington Medical School, 5 August, 1991. Jecker's lecture, in turn, was based on material from Principles of Biomedical Ethics by Tom Beauchamp and James Childress, 3rd ed. (New York: Oxford University Press, 1989).

⁹Beauchamp and Childress, 9. Portions quoted from this book are used by permission of Oxford University Press.

specific behavior in exact circumstances. Such precise definition is called *applied* normative ethics. In this ethic, theory is applied to specific problems with the result of the development of an action guide for ethical response.

The clinical decision making model developed by Jonsen, et. al., is in the category of an applied normative ethic. It seeks to apply the descriptive principles of biomedical ethics identified by Beauchamp and Childress to the specific area of clinical ethics. To understand this base in principles a brief examination and overview of the work of Beauchamp and Childress is helpful.

Principles of Biomedical Ethics

The approach of Beauchamp and Childress to ethical dilemmas is a deductive approach. That is, in order to determine action one proceeds from moral theory to principles to rules to judgment. When one is justifying an action the progression moves in the opposite direction, from action to rules to principles and finally to theory. No matter which direction one moves, this approach recognizes the importance of theory and the application of theory through accepted foundational principles. In such an approach, no matter which direction one moves, principles become key to choosing and justifying action. Even though, for example, one may not reasonably expect another to act outside of generally held norms of morality "we can question whether a proclaimed principle is in fact a commonly accepted moral principle, and we

can also ask whether an accepted principle should be replaced by another."¹⁰

Principles then, in this approach, supply the needed justification for action and these principles must be based and justified by theory.

Principles are action guides. But not all principles are moral action guides. A test of sorts is needed to discern if a principle as an action guide is moral. Beauchamp and Childress suggest three conditions must exist for a principle to be a moral action guide: supremacy, universality and human welfare.¹¹ Supremacy means "moral action guides are those that a person or society accepts as supreme, final, and overriding."¹² One would expect not to be suaded away from such an action guide and the morality of the action guide would be in a priority position even over important aspects of personal lives such as political heritage or religious affiliation. As such, almost anything to which an *individual* gives allegiance could claim supremacy but that alone would not make it moral. A moral action guide must also be universal. Universality is then a needed added condition. Universality means that a particular standard applies to everyone in relatively similar circumstances. Principles, then, are formulations out of universal rather than particular circumstances. The third condition for a moral action guide

¹⁰Beauchamp and Childress, 9.

¹¹Beauchamp and Childress, 17-21.

¹²Beauchamp and Childress, 18.

to meet is human welfare. This condition, although difficult to use by itself as a determinant of moral or nonmoral action guides is, nonetheless, central to the subject of biomedical ethics. Thus, a moral action guide must be in a priority position (supremacy), must be universally applicable to relevantly similar circumstances, and must contribute to the welfare (beneficence) of oneself or another.

Each of these conditions is important in determining if a principle is a moral action guide and if a moral action guide can lead to moral behavior. No one of them is sufficient in itself but together they provide a "test" for principles as moral action guides.

In Beauchamp and Childress' scheme of ethical discernment, principles that are judged as moral action guides are *prima facie* binding. In using such principles this way the authors reject a situational ethics approach. "Although situational or act-oriented theories recognize rules, they treat them as summary rules or rules of thumb that are expendable.... Such rules assist deliberation but can be set aside at any time according to the demands of the situation."¹³ Rather, Beauchamp and Childress understand rules and principles as binding but not absolutely binding, thus "*prima facie* binding." The idea is that principles are weighted differently in different situations but not discarded in any situation. This idea finds its origin in W. D. Ross'

¹³ Beauchamp and Childress, 48.

pluralistic deontology. Ross argued that there are prima facie duties that are binding on all occasions unless there is a difference with a duty of greater weight. To determine what one is to do in any particular situation, the prima facie duties must be weighed and compete for the greatest weight in a particular situation. In the same way, Beauchamp and Childress propose ethical principles which are prima facie binding and must be considered and balanced in any ethical decision and resultant action.

A Critique of Principlism

Before defining the prima facie principles that Beauchamp and Childress suggest for use in bioethical decisions, it is helpful at this juncture to introduce specific critiques of principlism to which this study wishes to respond.

1. The neat tie of theory, principle and moral judgment does not hold in actual practice. For example, people can agree about a particular judgment but not agree on the fundamental principle or theory behind the judgment. Stephen Toulman and Albert Jonsen both members of the U.S. National Commission for the Protection of Biomedical and Behavioral Research, report that agreement by Commission members was possible on specific cases but "when they tried to justify their concrete judgments in terms of general moral theories. . .their deliberations begin to resemble what is said to have occurred

during the construction of the tower in Babel."¹⁴ What this criticism points to is that in a pluralistic society where ethical and moral decisions are not mandated by an authoritarian agent, there is no universal theory that acts as a basis for principles and ultimately moral judgment. Rather than a negative, this study will consider this a positive factor and choose to encourage dialogue of the different theories as well as principles behind all ethical judgments.

2. A single principle in the rule based ethic of principlism can lead to two conflicting alternatives. For example, following a principle of beneficence can lead to a physician to conclude it is best to tell a patient the totality of their medical prognosis (sometimes referred to in ethics as disclosure) or the same principle may direct the physician to think it is beneficial to withhold information (non-disclosure).

3. Principlism makes a conscious effort to be a-historical and a-cultural. Therefore, religious convictions, professional obligations and the historical and social contexts in and of a moral problem tend to be ignored and purposefully avoided. This is a fundamental variance with the approach taken in this study. The model that Jonsen and colleagues will use to apply principlism will respond to this critique by providing one area of moral questioning that lumps together outside factors to be considered. It is the

¹⁴Thomas H. Murray, "Medical Ethics, Moral Philosophy and Moral Tradition," Social Science and Medicine 25 (1987): 639.

approach of this study however, that these nonmoral factors influence and interplay in all areas of the moral decision and in all principles that are the basis of an ethical action. It will be argued here that this is an essential part of a bioethical decision making model.

4. An emphasis on principles and rules can lead to an insensitivity to specific cases or particular aspects of cases which may be less relevant to a particular principle's application. The result can be a mechanical application of principles¹⁵ or a resort to "nonrule sources such as feelings, intuition, or conscience."¹⁶ This critique is partially overcome by the casuist approach used by Josen and colleagues and incorporated in this study. But this study, as in the critique no. 3 above, will advocate the inclusion of nonrule sources as important parts of the decision making process.

Far from being critiques that would lead to the discarding of principlism as a useful approach to bioethical decision making, the above critiques provide valuable commentary and correctives to make Beauchamp and Childress' principles and their application even more helpful as used in the casuist approach of Clinical Ethics and as refined by a covenantal theology.

The Four Principles

¹⁵Murray, 638.

¹⁶Beauchamp and Childress, 54.

The basic principles of bioethics defined by Beauchamp and Childress will be described in detail in succeeding chapters but a summary listing may be helpful in the flow of the current discussion.

1. Autonomy or respect for autonomy is the principle that requires equal respect for all peoples affected by one's choices. It is the belief that all persons are valuable and have a right to self-rule.

2. Nonmaleficence or inflict no harm is based on the maxim *primum non nocere* - first do no harm. Within the field of medicine it may be better served by the maxim do net benefit over harm since some medical treatments, chemotherapy, for example, do infact bring harm on the way to bringing benefit.

3. Beneficence is not just the flip side of nonmaleficence, but rather is its own maxim that requires positive steps to help others.

4. Justice as a principle has several facets to its definition. From its root definition of fairness, justice is encompassed in broad concepts of distributive justice, people's rights and moral law. Theories of justice (egalitarian, libertarian, and utilitarian) each emphasize a particular part or application of justice. It is therefore a difficult concept on which to reach unanimity of definition. However, it is a principle that readily involves ethical decision in the arena of community and as such it will be an important principle in this study.

The Casuist Approach

The history of ethical inquiry might be summarized (admitting the risk of oversimplification) as a combination of a theoretical approach based on rules and principles and a practical approach of ethics grown out of specific situations. These two approaches have been seen in tension more often than cooperation. Historically too, the casuist approach to ethics has been dismissed as far too disconnected from ethical theory and principle to make it credible. In the latter half of this century however, a casuist approach to ethics has been gaining favor, especially as medical issues become more complex and individual cases defy the strict application of principles in exactly the same way even in similar cases.

Two lessons have been learned that make a casuist approach helpful. First, the practical problems of morality today are exceedingly complex and require an immersion into all the facets of the case including the particulars of history and social context. Second, moral theories and principles are not self-applying. Increasingly there is need for interpretation within the framework of the tradition behind the principle and the specifics of any particular case to which a principle will be applied.¹⁷

¹⁷Murray, 639-40.

Arguing for a casuist approach in hospital ethics committees, David Blake outlines six features of a casuist approach based on the work of Jonsen and Toulmin.¹⁸

1. The importance of paradigmatic cases. The casuist approach starts with the study of cases that are paradigms for right or wrong conduct. "The idea here is that our motives of right or wrong grow out of actual experiences of exemplary conduct, and thus are not the result of theoretical speculations about the nature of the good and the right."¹⁹

2. "Warrants," or moral action guides, are drawn from the paradigm cases and the moral principles are developed, defined and understood in the context of cases. Rather than going from the theory to the principle to the judgment in a hierarchical manner of theoretical reasoning, the casuist moves "sideways" through the rules and principles and from one probable judgment about a case to another probable judgment. Thus, "the development of policies or guidelines, in the form of moral principles and generalized rules, would be done in a way that grounds the policy or guideline in a consensus of judgment about the same clear case and not in a theoretical commitment to either utilitarian, or deontology, or natural

¹⁸Blake, "Hospital Ethics Committee," 6-11.

¹⁹Blake, 9.

rights."²⁰

3. The limits of a lesson's application from one paradigmatic case to another are tested by the practice of altering and complicating the paradigm. Thus, as more cases are considered that add other dimensions to the case, conclusions are tested from several directions and one understands better what factors make the moral difference. Particularly attractive to this study is that the community (the hospital ethics committee, for example) decides over time when a case should be considered a paradigm. Thus, the principles as well as the taxonomy of cases come from the dialogue of the community wrestling most closely with the ethical decision.

4. There is an "acceptance of moral judgments as more or less probable but never axiomatically certain."²¹ Moral judgments, therefore, are made in new cases by how closely the new case relates to the paradigm case. This moral probablism gives the framework where ethical decisions can be made with a sense of being ethically sound and grounded without either being totally relativistic (since all judgments are related to lessons learned in other cases) or axiomatic (since a new case may add a certain dimension that refines the paradigm and thus the resultant action). This approach is a strength to this particular study precisely because, as the decision making

²⁰Blake, 9.

²¹Blake, 10.

process proceeds, the ethicist must remain constantly in dialogue with a tradition of cases and the principles behind them and with the contemporary case that is being considered. Such dialogue opens the decision to both the communities of the past experience and also to the new twist that is presented by the new case.

5. Casuistry pushes toward action even in the face of uncertainty. There is no retreat in this approach to a theoretical morass. Rather, it is in the process of decision making tested by final moral action that one becomes clearer about the lessons learned from one case to another and thus one's taxonomy of cases becomes a better and better tool of a range of paradigms with more and more applicability to the variety of future cases.

6. Resolution of different cases comes as one considers and weighs arguments and reasoning from all sides. In this approach, moral theory is not rejected but neither is one moral theory held or weighted more significant or valid than another. To the contrary. In the practice of difficult case review a particular theory might be appealed to for appropriate and helpful reasoning while in another case another theory would be the foundation for ethical action. There is value seen in all theory by the casuist but there is allegiance to none. Most important is the paradigmatic lesson to be learned from a case -- a lesson learned, in part, from dialogue with varying theory -- that can then be used as a foundation for a decision and an action in another relevantly similar case.

To the above list of features of the casuist approach could be added an additional function of the casuist relevant to this study. By virtue of the casuist's dialogue with cases, the casuist reflects back to the community in which he/she works, the community's moral system. However, it is also the casuist's responsibility to challenge that system and even the accepted moral principles that sustain it when new cases and moral questions bring out inconsistencies and needs for new paradigms. This is why the casuist approach is particularly suited to the enterprise of dialogue and interchange which is foundational to the covenantal ethics of this study.

Ethics and Clinical Decisions

This chapter now turns to a description of the Clinical Ethics model developed by Jonsen, Siegler, and Winslade.²² Their approach forms the bioethical side of the dialogue of this study. In succeeding chapters each area described here will be examined in detail. For orientation purposes an overview is now presented.

Clinical Ethics begins with the case under consideration. "The case [is]: a set of facts (person, time, place, actions, states of affairs, e.g., signs and

²² As used in this project, the term Clinical Ethics refers to both the book by that title authored by Jonsen, Siegler and Winslade and also to their casuist model of bioethical decision making. See Albert R. Jonsen, Mark Siegler, and William Winslade, Clinical Ethics, A Practical Approach to Ethical Decisions in Clinical Medicine, 2nd ed. (New York: Macmillan, 1986). Portions quoted from this book are used by permission from McGraw-Hill, Inc.

symptoms), opinions (diagnosis, prognosis, options), maxims (things to be done or avoided) and values (states to be sought or avoided)."²³

The presentation of a case is broken down into four component parts - medical indications, patient preferences, quality of life, and contextual factors. Each of these areas considers several factors, one of which is a principle or principles of bioethics. The foundational understanding of these principles is defined by Beauchamp and Childress. Although a principle can be considered in more than one area of the case presentation, it is considered in a unique way in one particular area. As information is gathered in each area of the case the moral question is defined and the issues are delineated. Then, the areas are "weighted" against each other, the taxonomy of relevantly similar cases is considered, and probable or reasonable resolutions are suggested.

The factors that define the morphology of the case are described in each of the four areas, sometimes called "quadrants" as they can be diagrammed as a grid for ease of discussion and presentation. A description of the factors in each quadrant follows.

Medical indications consider the principle of beneficence and the information contained in the diagnosis and prognosis; the goals of therapy that are realistic outcomes of medical intervention and that are defined as

²³ Jonsen, "Ethics and Clinical Decisions."

those that will most benefit the patient; the efficacy or inefficacy of treatment including the assessment of risks; and the futility or utility of treatment.

Patient preferences consider the principle of autonomy along with the factors of the patient's capacity to choose. Also discussed here is informed consent or refusal and the directives from a proxy for health care or advanced directives written or spoken from the patient. The ethical weight of this area is generally high in American culture and medical practice. In the Clinical Ethics approach, the attempt is made, at least in process, to keep this area in equal balance to the others. In the reality of cases, however, this area is generally given significant and perhaps even greater weight than the other areas in the final decision.

Quality of life includes several ethical principles that are complex but the principles of nonmaleficence and beneficence are strongly considered here. A definition of quality of life is "the subjective evaluation by an onlooker of another's subjective experiences of personal life."²⁴ Terms such as "well being" and "best interest" are used here and attempts are made to categorize the subjective evaluations into the areas of poor quality, minimal quality, and below the threshold considered minimal. Use of these categories is fraught with difficulty and is done not to justify decisions but only as a helpful way to organize subjective information and judgments.

²⁴ Jonsen, Siegler, and Winslade, 102.

Contextual factors, the fourth area, can tend to be the other-factors-catch-all category. However, for this study it becomes important particularly because it is the area where the interests, values and views of a broader community are considered. The principle considered in this area is justice along with factors such as family, costs, allocation of resources, research, confidentiality, public interests and legal considerations. The attempt of the Clinical Ethics model is to lump these socio-economic factors into one area. The challenge offered by this study is that these "other factors" play a strong role in each of the three previously mentioned areas.

On the positive side of the Clinical Ethics model is the recognition that these factors be considered at all when, traditionally, they have been intentionally left out with the rationale being that they were not *medical* concerns. Increasingly, in medical practice, as illustrated above, the patient is not only the individual in front of the physician but a population of patients. This raises complicated issues that in Clinical Ethics are reserved for the area of contextual factors but, in the actual practice of medicine become concerns in each area.

To respond to this reality of contemporary medical practice requires some additional tools and perhaps new ways of conceptualizing the areas of clinical ethics. It is to this task that this project is addressed.

CHAPTER 2

Covenantal Ethics

Introduction

In his book The Broken Covenant, Robert Bellah writes that the last common value of Americans is individual freedom. This, however, argues Bellah, was not the original intent in the minds of the founders of this country. Rather, freedom or autonomy rested on the capacity of the citizenry to participate in the social welfare of all. The broken covenant for Bellah is that the essence of public virtue has been sacrificed for the pursuit of self-interest. He states: "Whether the notion of self, lacking any larger identifications with social and religious realities, and the notion of interest without any encompassing contest of loyalties and obligations, can provide a coherent morality for a viable society is certainly open to doubt."¹

What Bellah points out as a problem for American society in general is, understandably, experienced in all of the pieces of American culture. The purpose of this chapter is to explore an alternative to the kind of self-interest that Bellah describes, particularly as it applies to decisions made today in the area of medicine. What is presented here is an alternative called covenantal ethics.

¹Robert N. Bellah, The Broken Covenant: American Civil Religion in Time of Trial (New York: Seabury Press, 1975), xiii.

Although several authors and sources will be drawn upon to define this approach, the works of H. Richard Niebuhr and James B. Nelson will be used primarily. Niebuhr's work in radical faith provides the foundation of a covenantal way of thinking in which relationships, response and responsibility are key concepts. Nelson's work in the theology of the body and its implications for incarnational thinking provide a way for covenantal ethics to relate very specifically to medical ethical decisions and problems.

History and Contemporary Context

With the beginning of the 1600s, several changes were taking place in world history that would have profound effects on all aspects of modern culture. "The political revolutions of 1620-1660 reflected a profound shift in world-view usually called the Enlightenment"² and which was the beginning of the secular religion of Humanism. This faith placed human achievement and accomplishment at center stage. This religion evolved concurrently with the age of modern science and became an important philosophical base of support. As scientific technology continued to advance, it seemed there was good reason to place one's faith in the scientific method. If there was a

²Benedict M. Ashley, Theologies of the Body: Humanist and Christian (Braintree, Mass.: Pope John Center, 1985), 61. In this and succeeding pages, Ashley traces the rise of the humanist worldview which he contrasts to the Christian but shows that with the advent of modern science, the Christian worldview often adapted the scientific/humanist worldview.

problem in society or individual life, humanism argued it is within the human capacity to solve it and science provided the tools for the solution.³

At the same time as these changes were taking place in the scientific world, dramatic changes were also taking place in the political world. The rise of capitalism in the West brought with it an emphasis on the individual's ability to produce and be self-successful. The opening up of new worlds to explore and populate began what became the greatest political experiment in the West in the modern era--American capitalism and democracy.

Together, the rise of humanistic thought, the new powers of scientific discovery and technology and the rise of political capitalism, have led to an experience, in the twentieth century, which places great, if not ultimate, faith in human achievement and given rise to a philosophy of individual autonomy as the trump card of ethical principles.

One aspect of modern scientific exploration is worth special note. As the age of discovery that preceded the modern era focused on the *macrocosm* of the world with ships sailing off to find new lands, the scientific-technological era focused on the *microcosm*. Modern science pursues

³ Although written in 1973, "The Humanist Manifesto" states quite clearly the basic belief of Humanism that began in the 1600s. In one section on ethics it states: "Reason and intelligence are the most effective instruments that humankind possesses. There is no substitute: neither faith nor passion suffices in itself. The controlled use of scientific methods . . . must be extended further in the solution of human problems. . . . critical intelligence, infused by a sense of human caring, is the best method that humanity has for resolving problems." See Ashley, 55.

breaking the world down to its smallest component parts as a way of discovering how things work and what causes what we observe and experience. This reductionist approach has led at least one critic to conclude: "It is therefore quite true to say that we know more and more about less and less."⁴ This approach has resulted in giving less attention to the relationship between the parts. The parts in the microcosm have become the world of reality and importance. The world of interrelationships in the macrocosm has become secondary and less relevant.

In terms of ethics, what happens in this microcosmic approach to life is that ethical decisions are also broken down into their component parts. They are dissected under the microscope of "principlism" in an effort to arrive at the discovery of the right or relevant ethical path to take.

On the positive side, this approach has indeed increased our understanding of our physical world and even the pieces that go into our ethical decisions. On the negative side, such dissection has left the relationships of the parts of one's study largely ignored. In the area of medicine, for example, it is only recently that there has been interest in a more holistic approach where attention is given to the patient's attitudes as a part of the healing process. This new idea is that a patient is more than a bunch of chemicals but is also the relationship of all of the parts of the

⁴ Jürgen Moltmann, God in Creation: An Ecological Doctrine of Creation (London: SCM Press, 1985), 2.

human being--physical and emotional. Still, the faith in modern medical science is far more on the microcosmic than the macrocosmic.

What is needed at the end of this century, is a new way of thinking -- a way of thinking that recognizes the importance of science and the scientific method but which can integrate this into a more holistic view of creation, the human person and the political realities of the modern world. The basis of this new way of thinking is found in the rediscovery of an old concept--the covenant. As Moltmann observes: "Integrating and integral thinking is impelled by the will to find a way into this covenant, this totality, this community; to arrive at an awareness of these things, to deepen them after they have been ignored for so long, and to restore them when they have been destroyed."⁵

It must be stressed, however, that what we are after is more than just a mechanistic understanding of the relationship of parts either within the human body, a society, or the whole creation. The concept of covenant is yet more inclusive and transcendent. It includes the concepts of revelation and promise, for example, examined later in this chapter, which enables covenant to be a concept that transcends an individual's or even a society's identity to include the center of value which is inclusive of time (past, present and future) and community (one's own and all of creation) , and, most important,

⁵Moltmann, 4.

focuses on the radical monotheism of radical faith that gives both substance and direction to ethical decisions.

Covenantal Ethics: A Definition

H. Richard Niebuhr begins to help formulate a working definition of covenantal ethics when he draws a clear distinction between covenant and contract. This distinction is important to raise at the outset since, in our individualistic society, when we *do* think of a relationship, that relationship is thought of in terms of a contractual relationship more often than not.

Niebuhr writes concerning the difference in viewpoint and approach:

"Contract always implies limited, covenant unlimited commitment, contract is entered into for the sake of mutual advantages, covenant implies the presence of a cause to which all advantages may need to be sacrificed. The tendency of the covenant idea to degenerate into the limited contract idea is evident in all the later religious and social history."⁶

What then shall we say of a covenantal ethic? Five aspects of a definition are proposed here.

1. A covenant is a formulation of community.
2. It transcends both the time and the community of the immediate context to include history and future, human and God.

⁶H. Richard Niebuhr, "The Idea of Covenant and American Democracy," Church History 23 (June 1954): 134.

3. Indeed, the meaning of the covenantal relationship, and therefore, the ethical decisions made within it, is derived from its transcendent dimension more than its contextual.

4. Likewise, the identity of an individual within the covenant community is derived both from its contextual and its transcendent sense.

5. Finally, covenant points to a community and context in which there is an ideal conformity of important principles such as autonomy, equality, and the common good while, at the same time, it calls upon an allegiance to a transcendent relationship that brings these principles into creative tension and conflict.

Having set the stage with this history and definition, important aspects of a covenantal ethic and its implications for moral decision making in medical ethics can now be outlined. The topics to be examined in the next sections are:

--Creation and Creativity. This topic examines an understanding of creation from the perspective of Niebuhr's theology of revelation. This section will establish the important concepts of history and God's active presence in history as a foundation for covenant.

--Identity. In this section the individual's identity is examined under two headings: a covenantal theology of the body and the individual's identity in community.

--Responsibility. In this area Niebuhr's important contributions to the relationship of individual to self, to God, and to community will be examined.

--Implications for Dialogue. The final section examines implications for the dialogue between covenantal ethics and medical ethics looking to a new definition of health and facets of ethical decision making derived from Niebuhr's theocentric relativism and Nelson's relational value theory.

Creation and Creativity

The Good vs. Meaning

In much of ethical decision making, the search is for the good or best thing to do in a particular situation. Options to determine *the good* or *best* thing have included traditional utilitarian (teleology) or rule based (deontology) ethics. H. Richard Niebuhr has argued against either of these alternatives using the metaphor of responsibility instead. His alternative, which will be discussed in detail, comes closest to the goal of searching for *meaning* rather than *the good* in ethical decisions.

A covenantal ethic is an ethic that takes history seriously, all of history, in arriving at an understanding of meaning. Contrary to contextual ethics, a covenantal ethic sees no situation as isolated in time but rather, related to events and individuals' histories which precede the situation and also related to one's anticipations of the future. Contrary to a deontologic ethic, a covenantal ethic sees all principles as relative to each other and even dependent upon a transcendent meaning. Niebuhr uses the metaphor "the

citizen" to describe a deontologic ethic whereby one is a good citizen as one follows rules and laws.⁷ Niebuhr sees this as helpful in so far as it clarifies objectivity and impartiality in moral judgment. But he finds it wanting in its lack of appreciation of changes in history and situations. Similarly, according to Niebuhr, a teleologic ethic, which seeks to define the good by the outcome of a particular situation, is helpful as it allows for human freedom and even historical change, but does not take into consideration past history or values that transcend history. His metaphor for the teleologic based ethic is "man the maker" highlighting the emphasis on human power to determine the future outcome by the good decision and action in the present.

By contrast with this teleologic way of approach, a covenantal ethic places ethical decisions within the context of all history and seeks to find the meaning of particular situations and the decisions, not only within the experience but also in the foundation provided by past history and the hope in the realized eschatology of God in the present and future history. In this regard, covenantal ethics finds guidance for decisions in the context of the *promises* of the covenant and not its rules; in the *context* in and over time, not just in the moment or in some future we can determine; and in the *inter-*

⁷For a detailed description and critique of the metaphors used in this section see H. Richard Niebuhr, The Responsible Self (New York: Harper & Row, 1963), 48-56.

relationships and dialogue in the decision making process and not in some false power of self-determination.

A covenantal ethic, therefore, searches for meaning rather than the good. Indeed, covenantal ethics sees "the good" contained within "the meaning" that the covenantal ethic discovers as the basis for action.

How does one discover meaning? To answer this question three important topics are considered: creation explores the area of history and historicity; creativity explores the important role of novelty and change within history; and revelation explores the revealed meaning in these concepts of history.

Creation

The different biblical traditions talk about God's creation in the perspective of the beginning of time, in the perspective of historical time, and in the perspective of eschatological time. So if "creation" is to be the quintessence of the whole divine creative activity, the corresponding doctrine of creation must then embrace creation in the beginning, creation in history, and the creation of the End-time: *creatio originalis* -- *creatio continua* -- *creation nova*. "Creation" is the term for God's initial creation, his historical creation, and his perfected creation. The idea of God's unity is preserved only through the concept of creation as a meaningfully coherent process. This process acquires its significance from its eschatological goal.⁸

While biblical tradition has held this concept of a process and direction to history, it was with Charles Darwin that the scientific community, from its own perspective, began to adapt a similar view of history. With Darwin, a

⁸Moltmann, 55.

scientific worldview was proposed that history is not a repetition of itself but a progression with a past, present and future. The human person could now be explained by an evolutionary process which was a combination of natural law and accident.

It is important to note the difference between the traditional biblical view and the emerging scientific world view. Even though both recognize a process and direction to history, the biblical world view understands this process is infused with meaning at every step. The scientific world view sees no transcendent meaning guiding the process. If there is meaning, according to the scientific world view, it is only that which is contained in the process itself. If the scientific world view and that of the covenantal ethic are to enter into dialogue, the common view of history as process is at least a beginning point.

It was Albert Einstein who was next to add another piece to the understanding of process. Einstein began to challenge the notion that history's process can be observed in the changes visible in Darwin's evolutionary model. Einstein's discovery of relativity and a mathematical view of the universe advocated two new perspectives which open the way for understanding that meaning may not always be visible.

1. Our human bodies are realities inaccessible to our understanding exclusively through our sensual experience of these bodies, and

2. The scientific method cannot hope to give us the understanding of ourselves or our world except as that which can be expressed in mathematical terms.⁹

Whereas this logical empiricism could have opened the door to dialogue with a religious world view that also argued for a process to history that is not understood totally in what is observable, instead, what took place was a resort to a dualistic understanding of history and creation whereby the scientific world view was given authority to explain the physical part of creation through its mathematical formulae and scientific method and the religious world view was given the realm of the spirit.

This dualism continued, in many forms, in both world views up to, and including, the contemporary era. The challenge to a dialogue between these two world views will not be answered by resorting to dualism. Rather, it must begin with a common understanding of creation as process. Then, a process that has direction, and finally, a direction that has a purpose. The two world views may choose different terminology to describe this purpose; nevertheless, it is on this field that the dialogue between a covenantal ethic and a scientific world view can take place.

⁹ Ashley, 65-68. In this section, Ashley evaluates Einstein's theory and places it in this context in the history of scientific thought.

Creativity

One way to view the purpose of creation is through the metaphor of creativity. It is in this metaphor that the concept of change and the novelty in change are not only included in the understanding of history's process, but also provide the place for a beginning to understanding of history's meaning. It is also in this metaphor that the process of history is seen as a unity of past, present and future. And finally, it is in this metaphor that we will find the context for ethical decision making -- a context that transcends particular situations.

One of the sacrifices of Einstein's mathematical approach to creation is the exclusion of the importance of novelty in change. Instead, Einstein and the scientific approach that followed his work aimed at predictability and reliability. Alfred North Whitehead responded to this approach with his notion of "creativity."

"Creativity" is the principle of novelty. An actual occasion is a novel entity diverse from any entity in the "many" which it unifies. Thus "creativity" introduces novelty into the content of the many, which are the universe disjunctively. The "creative advance" is the application of this ultimate principle of creativity to each novel situation which it originates.¹⁰

Key to Whitehead's view is the understanding creativity brings to history not as predictable steps in a mechanical process like putting building

¹⁰ Alfred North Whitehead, Process and Reality: An Essay in Cosmology, corr. ed., eds. David R. Griffin and Donald W. Sherburne (New York: Free Press, 1978), 21.

blocks together, but, rather, novelty introduces the possibility that change, and therefore, the whole process of human development, not to mention the whole of creation, has a meaning and a direction supplied it from other than observable and predictable mathematical process. This, then, is the foundation for an understanding that history, as exemplified in the novelty of change, has meaning, a meaning that is transcendent of mechanical process yet inclusive of it.

Creativity, however, involves more than an understanding of past and present history. Creativity, in a religious world view, includes the future in the meaning of creation.

Jürgen Moltmann describes this part of creativity this way:

All living things . . . exist in the direction of their future. Their future is the scope of their past and their environment. This means that their impulses, perceptions, ways of behaving and actions have an anticipatory character. . . . Consequently [people] continually cross the borders of their own present, projecting themselves towards the open possibilities of their future, and changing in the course of their historical existence.¹¹

Just as the past and present are important experiences of creativity and, in the novelty of change within past and present history we can begin to perceive meaning, it is in the anticipation of the future that meaning is also found. This is an essential ingredient for the religious world view of covenantal ethics. Creation (history) encompasses the whole of time. The

¹¹Moltmann, 264-65.

future, in a covenantal understanding, is the fulfillment of the promises of past and present. The relationship between the ages of time is an important part of the experience of a meaning which transcends all time. Further, one's participation in history is a participation in all its ages. One responds, in any given situation, to the present with the information and tools one has gained from the past but also with the anticipation of the future which is, again, based on the meaning that is a part of one's past and present experience.

In summary, a covenantal ethic is grounded in time -- past, present and future. In the novelty of change (creativity) rather than in the predictable mechanical universe, one finds the experience of meaning. Further, behind novelty is a transcendent meaning that has been experienced in the past, is experienced in the present, and is a part of one's anticipation of the future. Ethical decisions, therefore, are made within the framework of meaning which transcends time and yet includes all of the real experiences within time. Finally, decisions are made not with a need for a mathematical predictability of the outcome but, rather, with a faith in the anticipation that the One who is in the unpredictable novelty of the history of creation's past and present is also in the unpredictable future.

The question must now be addressed: How does one discern and know this meaning in creation? For the answer to this question we turn to H. Richard Niebuhr's understanding of revelation.

Revelation and History

In his book The Meaning of Revelation, H. Richard Niebuhr develops his theology of a God active in real history calling people to faithfulness in response to the actions of God in history. He shows how, in real history, God and sinful humanity come together in a continuing process of historical transformation. It is through this transformation (or creativity) that God is known and in this transforming process that God's humanity is called to be active participants. By responding to God's actions in history one becomes a part of and aware of God's revelation and the transcendent meaning of history.

Niebuhr addresses revelation as he responds to three problems germane to this discussion of a covenantal ethic: the problems "of the relative and absolute in history, the connections between 'scientific' or objective and religious history, and the perennial problem of natural religion and historical faith."¹²

Regarding relative and absolute history, Niebuhr argues that the Absolute God is only experienced historically in a relative way; nevertheless, it is God that is experienced.¹³ No one community may claim complete understanding of this God in history, much less embody this God in history

¹²H. Richard Niebuhr, The Meaning of Revelation (New York: Macmillan, 1941), ix.

¹³Niebuhr, Meaning of Revelation, 21-27.

(thus, relativism), but this God is known and knowable in history. Every encounter with God takes place within the context of community and history. Indeed, the community is formed by these historical encounters but even with this experience, a community can only claim relative, not absolute, understanding of history. Thus, meaning, even though revealed in history in real events and to real people, is not revealed absolutely. This leads Niebuhr to conclude:

Revelation cannot mean history, we must say to ourselves in the church, if it also means God. What we see from the historical point of view and what we believe in as we occupy that standpoint must be two different things. For surely what is seen in history is not a universal, absolute, independent source and goal of existence, not impartial justice or infinite mercy, but particularity, finiteness, opinions that pass.¹⁴

This leads to an examination of the second problem which is the relationship between a scientific and religious understanding of history. Niebuhr explains the different understandings by using the terms "internal" and "external" history.¹⁵

External history is the stuff of science and observation. Internal history, on the other hand, is the stuff of meaning. In the two understandings of history there are important differences in the conceptions of value, time and human association. External history is to be value free

¹⁴Niebuhr, Meaning of Revelation, 40.

¹⁵Niebuhr, Meaning of Revelation, 47-54.

and objective while internal history is where one finds one's values and self-worth. Time is also viewed differently. External history views time as quantitative meaning that the present builds on the past but the experience of the past is gone in the present. In internal history the past continues to live and be an active part of the present's experience. The future too is a part of the meaning and experience of the present as one's hopes and expectations impact one's present actions and experience. Finally, external and internal history differ in their views of human association. To external history, societies are made up of autonomous individuals and "even the human individuals are depersonalized, since they are understood as complexes of psychological and biologic factors."¹⁶ In internal history, society is seen as a "community of selves." In this community all selves live in each other and what affects one affects all even over the course of time.

In summary, revelation is both an experience of meaning and also a concrete practical experience in the activities of daily life. Internal and external designations begin to fade in the reality of experience in that meaning (internal) is derived from activity (external) and activity draws its initiation from meaning. The *two* are really *one*. From this understanding of two histories, Niebuhr can argue that God's presence, and, therefore, meaning, is known in both histories but not in either one exclusively. This

¹⁶Niebuhr, Meaning of Revelation, 51.

paper stresses the overlay of these two histories and the lack of a clear distinction between the two. Each history is an integral part of and influence on the other.

The third problem addressed regarding revelation is the relationship between natural religion and historical faith. To Niebuhr, all persons are born "religious" and, therefore, all have some sense that life has ultimate meaning and purpose. "Revelation is not the development and not the elimination of our natural religion; it is the revolution of religious life."¹⁷ Revelation is to transform the ideas and relationships we already have in history; to transform them into the understanding of the meaning of history.

This premise of Niebuhr's will provide the common understanding for the beginning of a dialogue between scientific and religious worldviews. If Niebuhr is correct, then both world views can admit to using different language and even approaches but in both there is a common understanding that life, has history, process, and direction. The question for dialogue is does this process have *meaning* which transcends particular events?

Finally, there is, for Niebuhr, an important responsibility to respond to this creative action of God; to be a full participant in this history and, therefore, in its meaning. This response requires a new understanding of our identity and the identities of the communities of which we are a part.

¹⁷ Niebuhr, Meaning of Revelation, 125.

Identity

As has been touched on previously, the problems of dualism are present in one's outlook on history and theology. This dualistic approach to life is in contradiction to a covenantal ethic. Although it is pervasive in all of life, it is particularly felt in the area of one's identity. This identity, it will be argued here, is one of integration. The integration of one's body and the integration of community are two essential ingredients to our identity.

A Theology of the Body

A dualistic approach to a theology of the body has been prevalent since the time of Plato, who thought the human person was split into body and soul with the body being the prison of the soul. With Aristotle this dualism was seen a little bit more positively in terms of a dynamic union with the soul being the vital principle of the body. However, the distinct separation of the two remained. Later, Descarte described the relationship as that of subject to object with the soul as subject rising to prominence over the object of the body.

It is of interest to note that the physical center of the *self* moved upward as the understanding of the duality changed.¹⁸ The implications of this are profound. As life was identified with breath, the self was located in the center of the body, with the diaphragm. This was the location for the

¹⁸This insight is described and elaborated by Moltmann in God in Creation, 255-56.

Hebrew, who did not understand a duality of body and soul but a unity. As the Jewish/Christian community moved into the Greco-Roman world, this unity gave way to a more dualistic understanding. As duality was introduced, the location of life or spirit moved away from the center and moved upward, first to the heart and then to the brain. So that today, one is truly not a living self when one is brain dead. The importance of this observation is that with our technological, scientific duality we have moved further and further away from a center of an integrated identity, not only in our understanding of our bodies but even in the physical location of the *self*!

With today's dualistic concepts, there is a fundamental conflict with a covenantal ethic. A First Testament understanding of the body, as seen above, does not differentiate between body and soul. The importance of this beyond what has already been said, is that by virtue of this integrated understanding, one further understands that one belongs to divine history as a full participant. Since there is no distinction between the mortal individual (physical body) and immortal being (soul), then one can see oneself as an integrated part of a history that is Divine.¹⁹

In the Second Testament, the enfleshment of the divine Word represents the union of body and spirit. Although the gospels all profess this mystery as truth in regard to the Christ, the influence of Greek dualism shows itself in

¹⁹Moltmann, 256.

the conception of the rest of human creation as a dualistic union (in tension at times) of body and spirit. Moltman, however, argues: "Enfleshment is the end of God's works in creation. It contradicts belief in creation if we define the human being's essential quality, and what corresponds to God in him, by subtracting the animal [body] and then regarding what is left as something on its own."²⁰

The approach of a covenantal ethic argues for an integrated understanding of the body -- a body-spirit -- that exists in dynamic union with neither having supremacy over the other. In this approach one can not say "I have a body" but rather, "I am a body." In developing this understanding of an integrated identity of the body, the work of James B. Nelson is particularly helpful.

In defining this integrated identity of body-self, Nelson draws a distinction between dualism vs. duality and dichotomy vs. polarity.

A dualism, like a dichotomy, is the sense of two different elements which may live together in an uneasy truce but are frequently in conflict. They are foreign to each other. This is different from duality -- or from its parallel term, polarity -- in which two harmonious elements essentially belonging together are yet distinguishable and may exist in creative tension.²¹

²⁰Moltmann, 245.

²¹James B. Nelson, Embodiment: An Approach to Sexuality and Christian Theology (Minneapolis: Augsburg, 1978), 37.

The problems created by a dualistic approach to body theology are many. First, the body may be treated as a thing that is really nothing more than a machine. True, even as a machine, it has value. But its value is directly related to how well or ill it functions, which fluctuates greatly over time. Even the definition of "adequate" or "below standard" function is a heavily culturally and situationally biased value definition and subject to vast changes.

Second, as one's body becomes a machine the body's experience, i.e., through the senses, has only a functional value on the way to something else. The experience or sensation of touch, feel, or emotion has no intrinsic value. They can be used as a means only to an end in this way of understanding body.

Third, as one devalues the senses and experiences of the body, one also devalues and becomes alienated from the neighbor because it is through the senses that one relates to others.²²

Fourth, although historically it was taught by Plato and others that through cultivating the mind and soul one could become closer to God, in truth, as one goes deeper into a dualistic understanding of the body, one is

²²It is worth noting, at this point, that this separation is in direct contradiction to Niebuhr's understanding of the "response triangle" of self-God-neighbor. Indeed, with Nelson, Neibuhr would say that one must be able to experience God and neighbor with an integrated body-self in order to be able to respond!

drawn further away from God. Alienation is a definition of sin. As we become alienated from part of our integrated body through dualism, we become alienated not only from our whole self but also from God and neighbor who are experienced and known through the relationship with our whole self. We are prevented, through such alienation, from true communion with God and also with neighbor.

Fifth, as can be seen by the descriptions of the last two problems, the integrated identity of the body is essential to a relationship with neighbor and the relationship with God. But it is also essential for the even more complete relationship of neighbor-self-God; the interdependent relationship of all three. If only part of the body-self is acceptable, then only part of my neighbor is acceptable and, as a result, only part of God is experienced and shared in relationship since God is embodied in neighbor as well as self. The alienation only grows deeper. One cannot know God or neighbor completely because one is alienated from a completely integrated identity of body-self. Truly, by this path one misses out on a miracle. "The experience of new life is a relational reality in which the miraculous and the everyday stuff of life are interwoven. The incarnation of God, the divine presence in and through human flesh, is always a miracle. . . . We experience new life of the body-self as a gift."²³

²³Nelson, Embodiment, 72.

An alternative understanding is clear. A covenantal ethic is built upon the foundation of an integrated identity of the body-self. It argues for the unity seen in the First Testament understanding of creation and against the Second Testament understanding of dualism for all but the Christ. It argues too, for science to recover its view of the interrelatedness of the physical world and a macro understanding of change and process rather than the disintegration of the body into component parts and elements. It is important to establish the necessity of this integrated body-self identity and the interrelationships of all bodies as a prerequisite to participating and experiencing fully one's identity in community and relationships within community.

Community

In his book Moral Nexus, James B. Nelson talks about the interdependence of "moral community, moral identity and moral style."²⁴ The moral nexus for Nelson is the place of intersection of these moral areas of our life. It is their relationship that determines one's ethics. This relational model is one that is very complimentary to H.R. Niebuhr's value centered ethics and is particularly well suited to a covenantal ethic. It is one that takes seriously the "dialogue" of moral formation, a dialogue that takes place

²⁴See Nelson, Moral Nexus: Ethics of Christian Identity and Community (Philadelphia: Westminster Press, 1971), 12-20.

within oneself, between oneself and one's community, and between the communities to which one belongs.

The chief characteristics of this relational approach according to Nelson are:

1. Moral reflection is more analytical than prescriptive. Another way of stating this is that moral reflection is more dialogue than solution.

2. The moral life is a responsive life -- life lived in response to other beings under God.²⁵ "Because relationships (not ideals or norms) are the primary 'stuff' of ethics, we must inquire into the meaning of a person's moral communities to him, particularly the meaning of the church to the Christian."²⁶

This responsive nature of the moral life means that ethics is primarily more indicative than imperative. Nelson quotes Paul Lehman who maintains that "the ethical demands acquire meaning and authority from the specific ethical relationships which precede and shape these demands."²⁷

Thus, the relational approach to ethics understands that one's morals

²⁵Nelson, Moral Nexus, 25-39. This responsive life is also an essential part of Niebuhr's moral formation and ethics and will be addressed separately and in detail in the next section of this paper.

²⁶Nelson, Moral Nexus, 26.

²⁷Paul Lehman "The Foundation and Pattern of Christian Behavior" in Christian Faith and Social Action, ed. John Hutchison (New York: Scribner's Sons, 1953), 107 as quoted in Nelson, Moral Nexus, 26.

are formed and practiced as a response first to God, for the Christian, and then to neighbor. However, a covenantal ethic is careful not to draw the line between God and neighbor too carefully believing that each is found, in covenantal relationship, in the other.

3. A relational approach recognizes that "norms are absolutely necessary but that they are not necessarily absolute."²⁸ In moral decision making, we respond more to the internalized moral communities of which we are a part than we do to norms. In the medical ethical field principles have taken center stage as a way to guide ethical decision making. A relational approach would argue that the principles are helpful as far they go but that of equal or more weight, in ethical decision making, is the way all who are a part of the decision making process use and apply these principles based on the moral communities that have helped form their values. The importance of this is that even while parties may be carrying on a dialogue about a principle, there are several other dialogues taking place simultaneously: an internal dialogue of each person with their own value forming communities; an unspoken dialogue of each person's moral forming communities with each of the other person's moral forming communities; and a dialogue with the future anticipations, hopes, and faith of all participants. Thus, although norms and principles are essential and are most often the things that are

²⁸Nelson, Moral Nexus, 26.

spoken of outwardly, they, in truth, do not constitute the main dialogue in the ethical discussion and, in the end, may have less to do with the decision reached.

4. Following closely on this last characteristic is the aspect of a relational approach which recognizes that one's values are also relational, i.e. they are not purely objective but are also subjective in that they are always based on one's experience and that of the moral communities.²⁹

In his work on radical monotheism, H. Richard Niebuhr adds a caution to the place of community in the ethical decision making process. He describes "henotheists" as those who replace God with the loyalty to community and community norms.³⁰ Even (and perhaps especially) the church is guilty of such "henotheism." Nelson responds: "If our self-critical ethics is Christian, we will affirm relative loyalties and value centers only in the wider context of faith in God alone who is worthy of absolute loyalty and who judges and converts all our relative evaluations."³¹

Still, given these cautions, the community is the center of our value formation and practice and, as such, is central to our identity. Indeed, it is

²⁹ Again the thought of Nelson complements and builds on that of H. Richard Niebuhr. For Niebuhr's discussion of the relational value theory, see "The Center of Value" found in Niebuhr's book Radical Monotheism and Western Culture (New York: Harper, 1960), 100-13.

³⁰ See Niebuhr, Radical Monotheism.

³¹ Nelson, Moral Nexus, 28.

the kind of integration of ultimate loyalty to God as the individual exists in community that provides for one's true identity as a part of community. This integration, just as the integration of one's body-self, provides the individual with the other crucial element of identity.

With this kind of integration, the community does indeed play an essential role in identity. The community is the place through which God works. It is the place where the self "comes to knowledge of itself in the presence of other selves and that its very nature is that of a being which lives in response to other selves."³²

As powerful as the community is and as important as it is, along with Niebuhr's caution regarding its henotheistic possibility, we must also add the clarification that community and individuality are not antithetical. They are two distinct parts of the same reality. The community is strengthened in its moral center as it affirms and supports the personhood of its members. Likewise, one's individual identity is best defined as one affirms the communities of which that identity is a part.

Finally, as one seeks to define his or her community, one must look beyond the narrow definition of one's associates. Indeed, if we are to guard against becoming henotheistic, then our community must have universal parameters. If God is the Creator of *all* creation and our first loyalty in

³²Niebuhr, Responsible Self, 71.

community is to this God, then our community of moral formation, responsibility and action must be this universal community of God's creation. "The responsible self is driven as it were by the movement of the social process to respond and be accountable in nothing less than a universal community. . . . When this monotheistic believer tries to understand his own life, he finds that it is life lived less under universal law and less in pursuit of a universal ideal than a life of responsibility in universal community."³³

In summary, one's identity is found in a relational dialogue that is both internal and external; an integration of one's body-self and an integration of body-self and community. This dialogue is not done in a vacuum nor without context. In the premise of this study, the dialogue takes place within a covenantal relationship. The next section is addresses to the character of that relationship.

Responsibility

Niebuhr's Imagery

In response to the two prominent camps of ethical approach, teleology and deontology, H. Richard Niebuhr offers a third approach called responsibility. His approach is uniquely suited to a covenantal ethic for it is based on relationships in dialogue with emphasis on the dialogue with God and neighbor. This two-way dialogue raises the key questions of

³³Niebuhr, Responsible Self, 88-89.

responsibility: *to whom* am I responsible and *for whom* am I responsible? In his essay, "The Responsibility of the Church for Society," Niebuhr describes this two-way dialogue.

To be responsible is to be able and required to give account *to* someone *for* something. The idea of responsibility, with the freedom and obligation it implies, has its place in the context of social relations. To be responsible is to be a self in the presence of other selves, to whom one is bound and to whom one is able to answer freely; responsibility includes stewardship or trusteeship over things that belong to the common life of the selves. The question about the one *to* whom account must be rendered is of equal importance with the question about the what *for* which one must answer.³⁴

The relationship between these two dimensions of responsibility is extremely important. If, for example, we say we are responsible to God the Creator, then, because of this part of the equation, we are responsible for the whole of creation. Likewise, if we choose to define what we are responsible for as our nation, our neighborhood, or our clan, then that to which we are responsible becomes a constitution, a street community, or a name.

In Niebuhr's idea of responsibility there are four elements: response, interpretation, accountability and social solidarity.³⁵ In The Responsible Self he offers this summary definition of responsibility that ties these four elements together:

³⁴Niebuhr, "The Responsibility of the Church for Society," in The Gospel, the Church and the World, ed. Kenneth Scott Latourette (New York: Harper & Bros., 1946), 114-15.

³⁵Niebuhr, Responsible Self, 56-65.

The idea or pattern of responsibility, then, may summarily and abstractly be defined as the idea of an agent's action as a response to an action upon him in accordance with his interpretation of the latter action and with his expectation of response to his response; and all of this is in a continuing community of agents.³⁶

A brief description of each of these elements will be helpful. It is important to keep in mind, however, that these elements are intricately tied together. They are not a sequential movement of events or steps taken in some action. They are all part at the same time of any responsible action.

Response— It is basic to the human creation that we respond. Some responses are involuntary, others are reasoned and chosen. All responses, by definition, are responses to actions upon us. It is not so much the action that has the self-defining meaning for us (our *identity* as referred to in the last section) but it is our *response* to the action which defines body-self. One often has options as to what response one should make to a particular action and there is much that goes into one's decision as to which option one chooses. Niebuhr's concern is with the "fitting response."³⁷ Such a response will be based, not on rules or ultimate good, but one's *interpretation* of the action upon one.

Interpretation— This element, Niebuhr suggests, "is not simply an affair of our conscious, and rational, mind but also of the deep memories that

³⁶ Niebuhr, Responsible Self, 65.

³⁷ Niebuhr, Responsible Self, 57.

are buried within us, of feelings and intuitions that are only partly under our immediate control."³⁸ The value of this insight is that it brings into play the conscious and unconscious part of our responses; the parts of our response which are based on past history and also future anticipation as well as current data. Responsible action and a covenantal ethic must take into account the multi-level dimension to the interpretations we bring to the actions we experience. Dialogue regarding ethical decisions must take into account the reality of multiple interpretations present in response to the same action. This is one of the primary values of specific community involvement in interpretation.

Accountability— As interpretation may look in the past and present for data with which to interpret an action, accountability looks ahead.

Our actions are responsible not only insofar as they are reactions to interpreted actions upon us but also insofar as they are made in anticipation of answers to our answers. An agent's action is like a statement in a dialogue. Such a statement not only seeks to meet as it were, or to fit into, the previous statement to which it is an answer, but it is made in anticipation of a reply. It looks forward as well as backward. . . . It is made as a part of a total conversation that leads forward and is to have meaning as a whole.³⁹

Thus, in anticipation of a response to our response to an action, accountability seeks to consider the reactions and consequences of our

³⁸Niebuhr, Responsible Self, 63.

³⁹Niebuhr, Responsible Self, 64.

responses and interpretations. This facet of responsibility, then, ties us closely with others and leads to consideration of the fourth element.

Social Solidarity– "Our action is responsible, it appears, when it is response to action upon us in a continuing discourse or interaction among beings forming a continuing society."⁴⁰ Thus, the importance of community. Note, though, the multi-dimensional importance of community. It is a part of the interpretation because its values and mores are part of the crucial data of interpretation. It is also a part of a continuing discourse in which no moral action is seen as a true end but only a continuing part of the dialogue of responsible response.

The Triangle of Responsibility

How does one apply Niebuhr's model of responsibility to the realities of Christian ethics and, particularly, a covenantal ethic?

This ethic is theocentric. It is God, the Universal God, the Creator, to whom one responds. However, as Niebuhr himself would caution, this God is not necessarily the same God as the God of the church or even biblical interpretation. Often these views are limited by their time, cultural context or theological blinders. Rather, this God is the First Person among a society of persons.⁴¹ This God is the "I" that calls us into such a relationship that

⁴⁰Niebuhr, Responsible Self, 65.

⁴¹Niebuhr, Radical Monotheism, 44-48.

our own self and God's-self become tied together in a process of constant action and response. The neighbor is now defined as the creation of this God and our responses to this creation are, at the same time, responses to God. Niebuhr calls this "radical faith."

Integration of the self in the presence of the First Person is not only an affair of the practical understanding of all events that happen to the self or its community. The elicited trust and loyalty of radical monotheism express themselves in the positive response to such events. The radical faith becomes incarnate insofar as every reaction to every event becomes a response in loyalty and confidence to the One who is present in all such events. . . . No action is directed toward human companions or toward other nations or toward animals, but is also directed toward the One who is their creator and savior.⁴²

An important corollary to this is that value and meaning do not reside inherently in things or persons or principles, but in their reciprocal relationship in the universal community. Thus, a covenantal ethic which takes seriously the bonds of community brought about by God's continuing action of creativity and which is responsive to that action in interaction with the self and community is, in Niebuhr's definition, a responsible ethic.

The "Fitting Response"

But, the questions remain: How do we know God's actions in history, and in situational moral dilemmas what is the fitting response?

To the first question Niebuhr responds that God's action is seen in a threefold pattern of Creator, Judge and Redeemer and can be interpreted by

⁴²Niebuhr, Radical Monotheism, 48.

looking at both the pattern of this threefold action and human response.⁴³

Further, it is God's purpose to *redeem* in all actions and thus, other parts of the pattern lead toward this purpose. God's actions, then, in the contemporary will reflect the patterns of history with the purpose of redemption being the chief purpose and direction.

The fitting response to such actions is both relative to the situation and grounded in the actions of God. Thus, just as there is a threefold action of God, there is a threefold fitting response.⁴⁴ These responses vary with the situation but always hold to a theocentric center and a universal community. It will be the task of the final section of this chapter to define the implications of such an approach and the focus of the dialogue with medical ethical principlism to see how the approach can be applied to a specific medical ethical decision making model.

Transformation

There is one important purpose of responsibility that needs to be highlighted before going on. In Christ and Culture, Niebuhr presents five options for the interaction of God in society or creation. The fifth option,

⁴³Lonnie Kliever, H. Richard Niebuhr (Waco: Word Books, 1977), 139.

⁴⁴Kliever, 139-45. In his endnote referring to the material in this section of his book, Kliever notes that his material is based on unpublished transcribed notes from a class lecture offered by Niebuhr. See note no.19, p. 200.

"Christ the Transformer of Culture,"⁴⁵ is the one which Niebuhr favors. It has profound implications for the purpose of ethical behavior. It is this transformative nature of God's interaction with culture that saves ethical decision making from sheer relativity. "This God, known in and through Christ, continually stretches and shatters, corrects and completes all piecemeal human efforts to know and to do the good -- a good that finally and fully is nothing less than the kingdoms of this world become the kingdom of God."⁴⁶

This is the center of a covenantal ethic. It is ethical decision making which seeks to align all moral life with the transformative work of Christ in all contexts from relationships between individuals and ethical decisions involving them to relationships and ethical decisions involving nations and all creation.

Niebuhr describes all persons as having "natural religion" or "natural faith." What then needs transforming is this kind of faith into radical faith and this kind of religion into radical monotheism. In the ethical decision making of covenantal ethics what this means is that all ethical choices need to be checked against the requirements of radical faith -- devotion and responsibility to an Absolute God and responsibility for the universal

⁴⁵H. Richard Niebuhr, Christ and Culture (New York: Harper & Row, 1951), 190-96.

⁴⁶Kliever, 59.

community. Such checking of one's ethical choices transforms them into fitting responses to God's actions in history.

It is the checking or dialogue between radical faith and natural faith which is the arena of covenantal ethics in bioethical decision making. Here the dialogue is between radical faith and principlism and what needs to be transformed is the confines of principlism which has not considered, to date, the radical faith of a covenantal ethic which is in dialogue with God and neighbor in the ways described by Niebuhr and adapted here.

It is important to note, with Niebuhr, that in such a dialogue of covenantal ethics *all* participants and approaches are transformed. It isn't that responsible faith has an answer to bring to the dialogue but, rather, brings an approach that expands the dialogue and, in its emphasis on listening as well as speaking in the dialogue, takes seriously: the place of the Absolute God in the dialogue; the past and present experience and future anticipation; and the inclusion of the larger community into the decision with equal weight being given to all participants while still holding to all being responsible to the Absolute God. In such a dialogue all come to the table together to be transformed by the *process* of a covenantal ethic as much, if not more, than by the resultant decision.

The implications of such an approach for bioethical decision making can now be examined.

Implications for Dialogue with Bioethics

In his work in medical ethics, Paul Ramsey uses the covenant metaphor for the relationship between patient and physician. He writes:

Covenant-fidelity is the inner meaning and purpose of our creation as human beings, while the whole of creation is the external basis and condition of the possibility of covenant. This means that the conscious acceptance of covenant responsibilities is the inner meaning of even the 'natural' or systemic relations into which we are born and of the institutional relations or roles we enter by choice, while this fabric provides the external framework for human fulfillment in explicit covenants among men. The practice of medicine is one such covenant.⁴⁷

Ramsey was one of the first to apply the metaphor of covenant to the area of medicine. However, it has a much broader application here than in his work. Although it is an appropriate metaphor to use, as Ramsey does, to describe the patient-physician relationship, covenantal ethics refers to all the relationships involved in ethical decision making and all the levels of dialogue that take place. The implications for this dialogue go much deeper and broader than Ramsey envisioned. At the same time, anyone involved in covenantal ethics is indebted to him for beginning covenantal thinking in the area of bioethics.

⁴⁷Paul Ramsey, preface to "The Patient as Person," in On Moral Medicine, eds. Stephen E. Lammers and Allen Verhey (Grand Rapids: Eerdmans, 1987), 42.

Strategies for Moral Decision Making

What H. Richard Niebuhr aimed to do in general in his formation of Christian ethics, covenantal ethics aims to do specifically in the dialogue with bioethics: transformation. This calls for a new strategy of moral decision making -- a strategy Niebuhr calls "theocentric relativism" in which all decisions are relative to their context and moral norms but are constant in their seeking to find a fitting response to God's action. So that, "every event becomes a response in loyalty and confidence to the One who is present in all such events."⁴⁸

This dialogue is possible with bioethics because a covenantal ethic begins with the premise of a common foundation in "natural faith." Further, a covenantal ethic understands that the actions and interpretations of God's actions transcend any one experience or expression of ethics or ethical principles, and therefore, can enter into dialogue with philosophical ethical principles and bioethics while seeking to be transformative and transformed by the dialogue process.

Such a strategy "argues that norms ought to be interpreted relationally (rather than objectively or subjectively) because it is more appropriate both

⁴⁸Niebuhr, Radical Monotheism, 48.

to the radical monotheism of the Christian faith and to our actual moral experience."⁴⁹

What, however, is essential in a strategy of moral decision making using a covenantal ethic is that the dialogue with the Absolute God becomes a part of the moral dialogue. This is a crucial change in the process. Heretofor, the dialogue has been only between patient and physician. Recently, the dialogue has been expanded to include the patient's family and, in the case of medical resource allocation, to include the larger community. Generally, in none of this dialogue has there been an attempt to interpret God's actions in all that is being considered. Or, if this has been considered in specific cases, it is taken as a separate issue off by itself rather than being integrated into all that is being observed and considered. The strategy of a covenantal ethic is to integrate the interpretation of God's actions as a full dialogue partner with patient, physician, and community and to interpret God's actions as being experienced and expressed by all three as well as transcending the experience of any one of them. Through the theological understanding described here, this integration can take place even if all the parties involved in ethical decision making are not Christian or view their Christian faith through different lenses. A radical monotheism sees God in and over all things and, therefore, integrates this God into ethical situations and dialogue

⁴⁹ Nelson, Moral Nexus, 106-07.

which have not been inclusive of God. "The more the Christian ethicist can learn about the actions and interpretations at work in a moral situation, the greater his ability to bring to light their real trusts and loyalties and turn them toward a theocentric universalism."⁵⁰

Community Involvement

As indicated above, the moral dialogue is inclusive of a wide community. The covenantal community of the covenant ethic is not just a concept in the Hebrew and Christian stain of thought, but includes all community opening up the dialogue between those who address their allegiance to the Absolute God and to those who would address their allegiance to another value center. In the view of responsible faith, even these other value centers could be a part of the Absolute God and, in the course of the ethical dialogue, may be transformed even, as in the dialogue, the understanding of the action and will of the Absolute God may also be transformed.

The essential ingredient is community. To isolate a medical ethical decision out of this arena is a travesty. As we have seen, even as one deals with one individual one deals with community. For the individual is composed of communities of the past and present. Ethical dialogue is never between individuals but always between communities.

⁵⁰Kliever, 146.

In a covenantal approach, the community plays an essential and, perhaps unique, role in ethical decision making. To describe this, a more definitive picture of covenantal community must be drawn.

In the Christian's ethical decisions, one's individual interpretations of the fitting response must be in dialogue with one's faith community. It is this community especially that shares a similar experience and understanding of God's actions which can help focus and clarify an individual's experience. This clarifying function of the community of one's interpretations ensures that an individual's understanding is not limited to one's own immediate experience. A covenantal faith community can provide a broader perspective and interpretation of action which is essential to responsive faith and covenantal ethics.

A covenantal faith community can also help define integrated meaning when one's own experience is one of disintegration. If one is suffering, for example, the meaning of that experience is transformed from pure organic pain to meaning in the shared compassionate caring of the covenantal faith community. Indeed, one's experience of pain is physically lessened when the suffering is cared for and shared by one's covenantal community of faith. For the Christian, it is this community that is primary as one enters the covenantal ethical dialogue.

However, this faith community can not be exclusive. When exclusivity happens, the ethical dialogue becomes henotheistic and not monotheistic.

Thus, other communities outside of one's faith covenant community enter the dialogue and the Christian enters this dialogue always asking the questions of responsible faith: To whom and for whom am I responsible?

Authority

This model of dialogue in the more inclusive community of covenantal ethics raises the question of authority.

In the field of medicine, the physician has traditionally been the authority. In medical history a physician's authority was based on "medical knowledge and skills, on the one hand, and commitment to the noble goal of healing on the other."⁵¹ What this model of authority does is place the basis for such authority not on any covenant between patient and physician, as Ramsey advocated, but on something totally within the physician him- or herself. This authority has been willingly granted, even by patients, as it was hoped (even if unconsciously) that by so granting this authority the physician would also be granted the power, far beyond their own skill, to heal. The ramification of this approach is that the patient is reduced to the organic disease to be treated and his/her own interpretation of what is happening, much less their own participation in the healing, becomes less and less relevant. The patient becomes mere object of the physician's authority.

⁵¹James Nelson, Body Theology (Louisville: Westminster/John Knox, 1992), 130.

Where is the community in such a model? Even the community that resides within the individual has been ignored as this dualistic approach to the body-self has been adapted to bolster the authority given to the physician.

In the covenantal ethic, final authority is ascribed only to the Absolute God. As we enter into dialogue and interpretation, we are under no delusion that we can possess the absolute authority to make a right or even a good decision. However, it is by sharing together our limited authorities, in the dialogue of covenantal community, that we take part in the creation of the event through which God's authority can be known and experienced. Indeed, as any one part of the dialogue tries to claim autonomous authority (even if faith does this), the absolute authority of God is undermined and even shut out. In the radical monotheism of covenantal ethics, God is the absolute authority. The mystery of covenantal faith is that it is in sharing with full acknowledgement our limited authorities that God's absolute authority can be known. Again, it takes the transformed community of radical responsibility to realize the power of this authority of God in ethical decision making.

A Radical Definition of "Health"

The understanding of what counts as "healthy" at a particular time in a particular society changes considerably in the history of civilization. It reflects the system of received values in the society in question, and serves the adaptation of the human body to the

demands of that society. But this does not mean that these ideas of 'health' are necessarily healthy in themselves.⁵²

What is needed today is a radical definition of health if ethical moral decisions are to be reached. We have made health an idol in contemporary society and our idol has been built on a dualistic model of the body and of the community.

In the body theology described above, the body is integrated in its identity as body-self. What is defined as human is this integrated body-self. "If we understood health as the strength to be human, then we make being human more important than the state of being healthy. Health is not the meaning of human life."⁵³

Meaning, as we have described it, is supplied by the total context of individual life within the divine creation and God's continued presence in it. This meaning is found in times of both health *and* sickness. It is present in life *and* in death. Therefore, it is not *health* which gives life meaning, but being human which defines human health!

In this scheme, one can not separate the body into parts to be treated. For the body-self is a whole. The resurrected body of Jesus testifies to the wholeness. The enfleshment of the Word in flesh shows its integrated identity.

⁵²Moltmann, 270-71.

⁵³Moltmann, 273.

Sickness is often experienced as disintegration. Patients will further this disintegration while trying to get healing by giving their bodies over to be treated by the physician as if they could disengage from the body to obtain health and integration again.

The dualism that leads to such attitudes regarding health and meaning has no place in a covenantal ethic. Health is not defined in organic terms and meaning is not defined by autonomous satisfactions. Rather, health is being fully human and being fully human is being in integrated relationship with one's self, one's neighbor and with God. It is in this integrated relationship that one truly finds meaning. A meaning still intact in sickness and in health, in life and in death.

Conclusion

In this chapter the theological side of the dialogue with bioethics has been described. It is a part of the dialogue that seeks to transform the foundations as well as the process of bioethical decision making. In succeeding chapters a dialogue with each of four ethical principles-- autonomy, beneficence-- non-maleficence, and justice-- will be carried out and a case study will field test the approach and the process of dialogue.

CHAPTER 3

Medical Indications and Covenantal Values

Introduction

This chapter examines the indications for medical intervention as described in Clinical Ethics, the principle of beneficence as described by Beauchamp and Childress that is the basic principle of consideration in this part of Clinical Ethics, and the issue of futility as a way of illustrating how covenantal ethics enters this part of the dialogue with Clinical Ethics. A case study on the issue of futility is used to bring all of the pieces of this chapter's study together.

Medical Indications in Clinical Ethics

Although the main focus of this first part of the dialogue that contributes to an ethical decision is on the clinical information available, Clinical Ethics, at the outset, recognizes a reality of clinical judgments that is the incorporation of values -- values of the physician and others in the health care team as well as the values of the patient and his/her family. These values can affect the decision in both positive and negative ways. For example, "values that a physician may be loath to admit may bias outwardly 'objective' judgments: anxiety regarding death and disability, disdain for certain kinds of person's lifestyles, racial prejudices, repugnance for the aged

or retarded."¹ Thus, it is of utmost importance that all involved in the interpretation of clinical data be as aware as possible of the value glasses through which they make their interpretation and on which they base their judgments. This study will examine how even the definition of what is "illness" and what is "health" is value-laden. To arrive at the best decision for treatment it is the responsibility of the physician to diagnose conditions, inform and educate, recommend action and treat patients with an open awareness of the values that are a part of each step.

A second important theme in this area is the clarity of the goals of medical intervention. These goals are only partially based on clinical data and often there may be several goal choices indicated by the clinical data and certainly there may be conflicting goals at times. It may be said, however, that *the* goal of medical intervention is beneficence and its corollary of nonmaleficence. To establish what will benefit the patient medically is the goal of this part of the Clinical Ethics model. Even as one tries to establish such medical goals, however, it is important to recognize that the final determination of the goals will not be determined by clinical data alone but will consider the preferences of the patient, the values of the physician and

¹ Jonsen, Siegler, and Winslade, 13.

patient, and the social, cultural, political and patient economic realities among other factors.²

To facilitate the clinical part of this goal setting, Clinical Ethics defines three forms of disease and the medical goals that might be set for each category. The three forms are given acronyms of ACURE, CARE, AND COPE.³

ACURE is an illness that can be readily diagnosed, treated and cured. CARE is an illness in which there are some disabilities that will be continuing; and although some relief is provided, the disease will eventually progress and cause death. COPE is a chronic disease where the goal is to provide sufficient relief from the debilitating effects of the disease.

The medical goals of treatment for each of these forms of disease is understandably different. In a broad categorical way they can be summarized. For ACURE the goals are "curing disease, saving life, preserving function, relieving pain and suffering, and restoring health."⁴ For CARE, the goals are "prolongation of life, relief of pain and suffering, maximal preservation of limited function and enhancement of the patient's dignity and sense of control regarding his or her disease and life."⁵ For

² Jonsen, Siegler, and Winslade, 15-16.

³ Jonsen, Siegler, and Winslade, 16.

⁴ Jonsen, Siegler, and Winslade, 19.

⁵ Jonsen, Siegler, and Winslade, 24.

COPE, the goals are "to assist the patient to live as independently and comfortably as possible [and] to maximize the patient's need for current and future medical intervention."⁶

The foundation under all of these goals is beneficence. It is this principle which will guide the physician as she/he makes their decision as to what options to present to the patient and ultimately what treatments shall be carried out. Therefore, before examining further specific ethical issues considered in the medical indications area of Clinical Ethics, it will be helpful to understand this foundational principle of beneficence. The definition of this principle, as is the case for principles in each of the areas considered in Clinical Ethics, is largely based on the work of Tom Beauchamp and James Childress in Principles of Biomedical Ethics.⁷

The Principle of Beneficence

The principle of beneficence is more than just a principle of contributing to another's welfare. In medicine it carries with it the *obligation* to do so. This might be called "positive beneficence" because it includes not only bringing benefits to one's patients through the practice of medicine, but also implies an obligation to actively prevent and remove harms. This pro-active

⁶ Jonsen, Siegler, and Winslade, 41.

⁷ At the 4th Annual Summer Seminar in Health Care Ethics held August 5-10, 1991 at the University of Washington Medical School, the work of Beauchamp and Childress was presented in just this way. The leader of the seminar was Albert Jonsen, one of the authors of Clinical Ethics.

definition is often where ethical conflicts arise as in the conflict between paternalism and autonomy.

Inherent also in this definition is the balancing of benefits and harms. In medical practice, beneficence is often a matter of proportionality and decisions about the most beneficial treatment will involve decisions of what action will bring about the greatest proportion of benefit over harm. According to Beauchamp and Childress, "the positive benefit that physicians and other health-care professionals are obligated to seek is the promotion of health, as defined in part by the patient's own values. . . . The harms to be prevented, removed or minimized include pain, suffering, disability, and death from injury and disease."⁸

Beauchamp and Childress in their definition of beneficence stress the *obligation* to benefit and they review several philosophers (Frankena, Singer, and Slote) who also advocate the obligatory nature of beneficence but define the parameters of this obligation differently. This leads the authors to conclude the need for specific conditions of beneficence that will enable one to judge the level of obligation. In their framework of obligation, "X" is obligated to beneficence toward "Y"

if each of the following conditions is satisfied and X is aware of the relevant facts:

1. Y is at risk of significant loss or damage;
2. X's action is needed . . . to prevent loss;

⁸Beauchamp and Childress, 196.

3. X's action . . . has a high probability of preventing it;
4. X's action would not present significant risk, costs, or burdens to X; and
5. the benefit Y can be expected to gain outweighs any harms, costs, or burdens that X is likely to incur.

From these conditions one can conclude that the obligation to benefit is a highly subjective and value intensive judgment. It depends more on the weight of the moral obligation felt by both parties involved than the weight of a moral maxim to obligation. This conclusion is important to the thrust of this study, which also advocates that moral obligation is dependent on a social contract (covenant) to which the participants agree to be a part. Such an understanding places the physician in a position of moral obligation to beneficence not solely because of training and skill or professional oath but because society has placed in the physician the trust of training and license. Medical practice, then, is a reciprocal trust, meaning that because society has entrusted and licensed the physician, the physician, in return, is *obligated* to beneficence in his/her use of skill and license. By this covenantal agreement in society, beneficence becomes a *prima facie* duty of medical practice and a *prima facie* principle of bioethics.

In practice, beneficence is not without its tensions. This tension can be seen particularly in the conflict between beneficence and autonomy (a conflict

⁹Beauchamp and Childress, 201.

sometimes referred to as paternalism), and also between beneficence and justice.

With regard to the first tension, historically, as long as beneficence was the primary ethical principle of medical practice, the physician could rely on her/his own understanding of a patient's needs. With the claims of autonomy, however, this attitude has been challenged and has led to an understanding that sees beneficence as opposed to autonomy rather than complementary to it. Certainly, in the approach of this study, beneficence can not be practiced rightly without the inclusion of the respect for autonomy. By definition, in this study's perspective, one can not benefit a patient and ignore his/her autonomy. This subject will be examined further in the next chapter.

With regard to the second tension, that between beneficence and justice, Beauchamp and Childress refer to the need to balance cost, risks and benefits.¹⁰ To accomplish this, there have been a number of models, including "cost-effectiveness analysis" and "cost-benefit analysis," but the underlying issues, as the authors correctly address, is the valuing of lives and how this is to be done. Again, there have been a number of formal methods designed to help place a value on human lives in a particular ethical decision. Although understandable as a goal to make ethical decisions less

¹⁰ Beauchamp and Childress, 228-30.

murky, it is lamentable in terms of its implications both for the definition of what is "human" but also in its suggestion that a methodology of ethics can be developed much like the orderly process of a scientific blood test. It is a foundational assumption of a covenantal ethics approach that the important part of an ethical decision is the *process* by which the ambiguities and uncertainties of human life are considered, not the formulas used to put this life under a microscope. Certainly where this approach to beneficence will be tested is when it conflicts with justice, but the answer to this conflict is not in a formula for determining value for human life. The idea itself is self-contradictory. Human life has a value individually as well as socially but this value is not static in either case and will be determined differently with different cultures, situations, and circumstances. This, added to the understanding that a conflict between beneficence and justice may be more of a challenge to a society's concepts of distributive justice than to a determination of the value of a human life, there is a situation in this tension which calls out for a radically new way of dialogue and resolution of the tensions.

Beauchamp and Childress conclude that only under special circumstances are the obligations to beneficence great enough to override the respect for patient autonomy. They also conclude that in the tension between beneficence and justice, determining the *value* of human life is very subjective and not at all an objective thing to do. These two tensions between

beneficence and autonomy and justice are particularly present in the issue of medical futility.

Medical Futility

Since, in this study, the Clinical Ethics model is being used as the basic decision making model, it is helpful to understand medical futility in that perspective. In seeking this understanding other writings by some of the authors of Clinical Ethics will be considered. In this way the concept will be more completely outlined and updated.

Trying to define futility is a complex task. Many efforts have been made to define medical futility with the results including everything from attempts at definitions based on clinical data (the 100 case consideration of Schneiderman et al.)¹¹ to conclusions that a definition at this point is too ambiguous because of the disclarity between data and values (Callahan).¹²

Clinical Ethics stresses a careful distinction between short-run and long-run efficacy in establishing a working definition of futility. The tendency, say the authors, is for physicians to concentrate on the short-run efficacy and therefore treatments are prescribed and instituted which serve only to exacerbate the total medical condition rather than really providing

¹¹Lawrence J. Schneiderman, Nancy S. Jecker, and Albert R. Jonsen, "Medical Futility: Its Meaning and Ethical Implications," Annals of Internal Medicine 15 (1990): 949.

¹²Daniel Callahan, "Medical Futility, Medical Necessity: The-Problem-Without-A-Name," Hastings Center Report, July/August 1991, 30-35.

benefit. Medical futility becomes more difficult to define in such a scenario because one can, many times, find something to treat even if it will not measurably change the course of the disease. Therefore, Clinical Ethics proposes that "medical intervention can rightly be called *futile* [when] the results are temporary and fleeting and will not improve the patient's condition."¹³ The authors use several case studies to advise that it is ethically permissible for a physician to discontinue or not institute treatments that are deemed futile. The question of who makes this determination is next to consider.

Jonsen has collaborated with Jecker and Schneiderman to address this issue more completely. Subsequently, Jecker and Schneiderman, on their own, have together and individually expanded upon their initial work. Taken together, a composite and updated picture of medical futility that is still faithful to the Clinical Ethics approach is achievable.

There are two additional distinctions to be made in defining and applying medical futility: effect and benefit and qualitative and quantitative futility.

It is important to distinguish between treatments that may affect a patient and those that truly benefit a patient. The difference is that an effective treatment is aimed at a particular condition but it may not bring *net*

¹³Jonsen, Siegler, and Winslade, 27.

benefit to the patient. For example, "nutritional support could effectively preserve a host of organ systems in a patient in a persistent vegetative state, but fail to restore a conscious and sapient life."¹⁴ The advice of the authors in such a situation is that "treatment that fails to provide such a benefit -- even though it produces a measurable effect -- should be considered futile."¹⁵

This distinction is particularly attractive to this study for it is aligned with a covenantal approach to the body and human life as a whole. It is also a step away from the practice of medicine as a purely clinical exercise and into a more wholistic approach. However, covenantal ethics is critical of this approach in the area of *determining* what is "net benefit." The authors are more exclusive in their approach than is covenantal ethics in its approach. Schneiderman and colleagues advocate the unilateral authority of the physician, especially in determining what they term quantitative futility.

Quantitative futility is a judgment regarding the probability of a certain treatment to produce the desired results. The authors recommend a standard of 100 cases to determine probability. This means that if "in the last 100 cases, a medical treatment has been useless, [physicians] should regard that treatment as futile."¹⁶ Later, Jecker and Pearlman argue that in

¹⁴Schneiderman, Jecker, and Jonsen, 950.

¹⁵Schneiderman, Jecker, and Jonsen, 950.

¹⁶Schneiderman, Jecker, and Jonsen, 951.

some cases of quantitative futility determined by this standard, the physician has the sole authority to render such a judgment¹⁷ Such a unilateral authority is opposed by a covenantal ethic.

Qualitative futility judgments are less clearly defined but, say the authors, not elusive. They become elusive only when the above distinction between effect and benefit becomes confused. Therefore, the authors propose that qualitative futility can be "any treatment that merely preserves permanent unconsciousness or that fails to end total dependence on intensive medical care [that such] should be regarded as nonbeneficial and, therefore, futile."¹⁸

But, who makes these judgments? The authors advocate that patients and their surrogates do have a role in qualitative futility judgments but that, again, the final authority and determination rests with the physician. "We reiterate that the distinction between medical benefit and effect justifies excluding patients from determination of qualitative futility."¹⁹

In another article, Schneiderman and Jecker propose a variation on this almost unilateral physician approach to futility determination while maintaining the unique role and authority of the physician. They state that

¹⁷Nancy S. Jecker and Robert A. Pearlman, "Medical Futility, Who Decides?" Archives of Internal Medicine 152 (1992): 1140.

¹⁸Schneiderman, Jecker, and Jonsen, 952.

¹⁹Schneiderman, Jecker, and Jonsen, 953.

"as in the case of the definition of death, the medical profession at best can *propose* a definition of futility, but ultimately society at large will *decide* the definition of futility."²⁰

Again, the authors seem to combine too easily, in this study's view, the clinical and value judgments. The assumption that death has been defined conclusively as a clinical understanding that is value free is debatable. In actual practice, decisions about termination of life support, for example, point up other factors that are value judgments of both physicians and patients that impact even clinical determination of death.

The question then is who decides medical futility and using what definition. In the approach of Clinical Ethics this will be answered only in the course of case consideration. Jecker takes just such an approach in her 1992 article with Pearlman where she examines qualitative futility as it relates to a specific case. What is illuminating about this article, in light of the others cited in which Jecker was a collaborator, is that when judgments are made in specific cases (if this case can be a paradigmatic example) there is a need to involve intensive dialogue between physician, patient and/or the patient's surrogates to make determinations. And, even though Jecker still maintains the physician is not obligated to give treatments that he/she determine are quantitatively futile, the place of community and patient

²⁰ Lawrence J. Schneiderman, and Nancy Jecker, "Futility in Practice," Archives of Internal Medicine 152 (1993): 437.

values is elevated in determining qualitative futility. She stipulates: "Settling controversies about who should be assigned a right to make futility assessments requires acknowledging community value and goals and shaping a broad consensus of opinion that reflects these."²¹ To come to such a consensus will require, in some instances (cases) a reconciliation of different perspectives, especially, perhaps, those of the physician and the patient. The admirable (and achievable) goal is to come to consensus in fashioning standards on a broad definition level but especially on a case by case level. The concept of medical futility is not ambiguous and does not need to be practiced in an authoritarian way (either by physicians or by patients who demand futile treatments). But, through an application of covenantal ethics and clinical ethics on a case by case basis medical futility may be one guide to determining the medical efficacy of some treatments.

A Covenantal Approach to Medical Indications

Values and Clinical Decisions

A primary concern of a covenantal ethic applied to bioethics is the recognition that virtually all decisions are value-laden. In the effort to dichotomize human life into observable and factual from the spiritual, the scientific method has also led to the misconception that at the clinical level at least, scientific data is value free. This, in turn, has led to the assumption

²¹ Jecker and Pearlman, 1141.

that a clinical diagnosis based on scientific tests can also be value-free. The years of medical practice have shown otherwise: "Values can influence not only what facts are identified as facts, but also which ones are thought worth having and which are worth dismissing."²² Callahan calls this "the-problem-without-a-name" and describes it as the situation of making moral judgments that, of necessity, must combine factual and normative ingredients. It is not a new struggle but the complexity of today's clinical decisions and options made possible by technology have made the experience of "the-problem-without-a-name" more common.

Veatch and Spicer add that even when arriving at the best scientific decisions the formulation of data depends on underlying beliefs.²³ This does not imply of course that the clinician should not make such judgments. It does mean that collaboration is a better way for a clinician to make such a judgment so as to check one's beliefs against another's.

Such collaboration might be called clinical collaboration but certainly it is not the only collaboration needed. In several studies cited by David Orentlicher, the conclusion was that "physicians' values may be a more

²²Callahan, "Medical Futility, Medical Necessity," 30.

²³Robert M. Veatch and Carol Mason Spicer, "Medically Futile Care: The Role of the Physician in Setting Limits," American Journal of Law and Medicine 18, nos. 1-2 (1992): 19.

decisive factor than patient values [in end-of-life decisions.]"²⁴ Even more troubling was the conclusion that "patient's preferences were respected as long as physicians thought that the patient's choices resulted in the best decisions."²⁵ What these studies show is that the problem is not only in the absence of open acknowledgement and consideration of the underlying values and beliefs present in a physician's diagnosis, but that these beliefs play a trump card against the patient's. True collaboration between physician and patient in the decision making process of a more open and honest sort is called for.

Even the ethical principle of beneficence involves a decision and action based heavily on physician and patient values. Covenantal ethics sees this not so much as a problem as a golden opportunity to make clinical decisions more complete by incorporating into them a recognition and open consideration of values. This requires physicians and patients find ways to incorporate the identification of their values into their discussions of diagnosis and treatment. A goal of covenantal ethics is the transformation of the current relationships between physician and patient and of the ethical process and content of the ethical discussion. By bringing to bear a model of Christ the Transformer of Culture (see H. Richard Niebuhr, Christ and

²⁴David Orentlicher, "The Illusion of Patient Choice in End-of-Life Decisions," Journal of the American Medical Association 267 (1992): 2101.

²⁵Orentlicher, 2101.

Culture) the Christian covenantal ethicist can advocate and facilitate a new way of ethical decision making. Some of the elements of this transformed dialogue can now be identified.

The Definition of Disease, Illness and Health

Since covenantal ethics advocates a theology of the body which is wholistic and integrated, a disease or illness is not just a matter of cells and organs but of the total body-self. This not only means wholistic medicine where the body's parts are seen to be interrelated to each other and affected by the emotions, but it means an understanding of body-self which includes physical and spiritual and which understands each part as integral to the whole body-self. In such an understanding, disease is not an isolated concept. One does not say, for example, that my *stomach* is sick but rather *I* am sick, and the "I" is a totality of physical, emotional and spiritual. An illness is not just a matter of a part of the self but is a reality of the whole self.

Similarly, health is also a more inclusive concept so that the goal of medicine is not just to heal the stomach but to restore to health. Such more inclusive understandings effect the whole way we look at medical indications.

A Question of Meaning, Not Just Treatment

Clinical Ethics helpfully points out the importance of clarifying the goals of medical intervention. However, these goals tend to be set by the clinical data so that the process might work as follows: Physician "A"

completes clinical tests on patient "B" and determines, based on other relevantly similar cases, what the best treatment procedure would be. This is communicated to patient "B" and treatment, if agreed to, is carried out. This model is fairly widely accepted and has kept the clinical practice orderly. But order may not be the most important consideration.

In such a process the weight of the clinical data is considerable. In American culture, at least, the possession of good, hard data is deemed the best way to make a case for a particular argument or decision one wants to make.²⁶ The result is that the physician comes into the patient relationship with "the data" and, without intending it perhaps, the patient is in a secondary and dependent position. Part of this is expected and understood. The patient is coming to the physician for her/his expertise, but it is important to be aware of the power in the clinical data. In the simplified example above, the tests have even been chosen and conducted without ever considering the underlying goals of the patient, which could very well indicate a different approach to the clinical data needed. In other words, medical goals need to be set but within a framework that allows the patient's goals to be considered earlier in the process. In such a scenario, it is more

²⁶ "The possession of good information -- hard data -- is seen as the best way to make a political case, often by disguising or minimizing the influence of ideology and interests." Callahan, "Medical Futility, Medical Necessity," 35.

likely that the whole medical experience will contribute to the meaning of one's health and not just a treatment for one's organic parts.

A Question of Time

In the earlier discussion of futility, the importance of distinguishing between short-run and long-run effects of medical treatment to determine medical benefit was highlighted. This question in medical diagnosis introduces the important question of time in the indication for medical intervention.

In covenantal ethics an individual can only be seen in the context of inclusive time. This means that a decision regarding treatment is not only a response to the present organic realities but also to one's sense of the history of which one is a part and to one's future hopes and expectations. In covenantal ethics, time as defined by an active covenantal God profoundly influences one's values. Indeed, one's values are grounded in the understanding that the meaning of time is supplied by God's activity in history with covenantal faithfulness. Therefore, covenant and promise become the conceptual pillars of the framework in which values are formed and used to make decisions about one's life. In such a context, the good treatment decision is defined not only by its effect on the present but how it fits with one's past and future. This is the way meaning rather than just clinical good is defined. It is not enough, for example, to know one can

perform a liver transplant but the meaning of such a clinical procedure will depend on the person's lifestyle and future expectations.

Authority

As discussed in Chapter 2, covenantal ethics redefines the authority of the physician. Certainly, the knowledge and skill that the physician possesses enables him/her to make an essential contribution to the decision about the indications for medical intervention. The authority for such intervention, however, is not unilaterally the physician's but is a shared authority with the patient in the covenantal relationship.

In recent medical practice authority has shifted from the physician to the patient. The number of malpractice suits is just one of the contemporary indications of this reality today. The covenantal ethic does not argue for a return to the paternalistic authority of the past nor a patient authority model seen today. Rather, in the process of deciding what treatments are to be chosen based on the medical indications, the authority is shared by increasingly more inclusive communities depending on the needs and dynamics of the particular case. In some cases, the authority is shared between physician and patient. In others, the patient's covenantal community (family and faith community) may need to be included for consultation. And, still in others, the authority of the society will need to be considered. Since, in covenantal ethics, the final authority is the Absolute God and not individuals or any human community, only by sharing the

limited authorities of all the parties involved is a responsible decision reached.

Responsibility

In a covenantal ethic, as one is responsible *to* God the creator, one is responsible *for* the creation. Such an expansion of responsibility profoundly affects the clinical ethical model of decision making. Traditionally, the physician has had two foci of responsibility: one, to his/her teachers (Hippocratic maxim) or, in the contemporary expression, to the peers and state that licenses the physician and, two, to the patient. The covenantal ethic broadens this circle of responsibility.

In the area of responsibility to the patient, the physician becomes responsible for the patient which means the *whole* patient -- values, past history, future hopes. This is truly *wholistic* medicine!

In the area of responsibility *to* the licensing group, the physician becomes responsible *for* the society. In the area of medicine this means that indeed the physician treats populations, not just patients. This does not mean that the physician unilaterally decides a method of rationing health care, but neither does it mean that the physician is free to use unlimited resources in the treatment of every patient. This subject will be taken up in detail in Chapter 7, but mentioning it here emphasizes an important

implication and application of the responsibility of decisions for medical intervention.

The Role and Authority of the Physician

In a covenantal ethic should a physician be required to provide a treatment that he/she feels will be of no net benefit? Traditionally and in contemporary literature a physician has been granted the right to refuse medical treatment he/she deems to be of no overall benefit.²⁷ There are two levels at which this refusal might be made: on the level of clinical evidence and on the level of conscience. Covenantal ethics would agree that under the understanding of shared authority in ethics a physician, even on the basis of conscience and conflict of value alone, should have the right to refuse treatment that she/he sees as bringing no net benefit.

Veatch and Spicer argue differently. In such cases, says Veatch, another physician should be found who can carry out the patient's or surrogates wishes but failing that, a physician should be required to carry out the patient's or surrogate's wishes if there are no other negative factors present.²⁸ This is a troubling conclusion but in the realities of the contemporary situation, it may be where the line needs to be drawn for now.

²⁷ See Veatch and Spicer, "Medically Futile Care"; and "Council on Ethical and Judicial Affairs of the AMA: Guidelines for the Appropriate Use of Do-Not-Resuscitate Orders," Journal of the American Medical Association 265 (1991): 1868-71.

²⁸ Veatch and Spicer, "Medically Futile Care," 24-28.

This reality only points out the important need for some kind of a process whereby such situations can be avoided through an honest and open discussion of values as well as clinical evidence. It is the conviction of this study that such a process could lead to the withdrawal of the request by a patient or surrogate for the treatment that they are able then to conclude has no ultimate benefit or that the physician's conscience might not be violated as he/she is able to see the benefit through a family's value system and thereby be able to carry out the treatment. Certainly, the facilitation of such a process could be undertaken by a community based ethicist or ethics committees who understand a covenantal ethical approach.

A Covenantal Ethics Approach to Futility

Covenantal ethics, as used here, questions the useability of the concept of futility as a clinical concept for the final determination of treatment. This is not to say that there should not be efforts by society to define the limits of medical intervention. Indeed, a responsible covenantal ethic sees this as an important task in contemporary medical life. The argument here is summed up by saying that using futility as a clinical concept masks the values and meanings that are the real essential determinants of what is or is not appropriate medical intervention.

Schneiderman and colleagues, as described above, offer helpful distinctions between the effect and benefit of medical intervention and in the definitions of quantitative and qualitative futility but the presumption is still

that futility is a useful and usable clinical concept for determining treatment. Covenantal ethics argues otherwise.

Schneiderman et al., argue that values are an important part of qualitative futility but argue that quantitative futility can be purely a clinical judgment based on the 100 case comparison. For two reasons this is not helpful to a covenantal ethic. First, who is to say that the 100 cases used are relevantly similar? If values are indeed a part of the determination of medical intervention then can one say that the physician's values in all 100 cases were relevantly similar? Are the goals in all 100 cases similar? Goals not solely in terms of physiologic goals but wholistic health goals for all of the patients? Certainly, these factors would be almost impossible to determine; nevertheless, if futility is to be used as a tool of clinical ethics, they are important determinants in the decision about what is and is not clinical futility. Second, even with a 100 case standard, futility is a matter of probability and the statistical probability of a particular therapy as applied to a patient is still more a matter of judgment than science. Drs. Robert Truog, Allan Brett and Joel Frader agree: "Even if we could agree on a statistical cutoff point for determining futility, physicians are often highly unreliable in estimating the likelihood of success of a therapeutic intervention."²⁹

²⁹Robert D. Truog, Allan S. Brett, and Joel Frader, "The Problem of Futility," New England Journal of Medicine 326 (1992): 1561.

As mentioned above, a key part of the decision making process is the establishment of the goals of therapy and how one approaches the goals for medical intervention will effect the determination of futility. Truogg et al., state that, "the decision that certain goals are not worth pursuing is best seen as involving a conflict of values rather than a question of futility."³⁰ These values that are a part of the goals are bypassed in the determination of futility if they are only considered in qualitative futility. Covenantal ethics would hold that both qualitative and quantitative futility assessments are value assessments and should be acknowledged as such in the determination of the goals of treatment.

How are goals to be established? This is an important question for covenantal ethics. Currently, the public attitude seems to be that medical science exists to satisfy all the individual's health needs within the limits of science and perhaps, the limits of the ability of the third party payers to pay. Covenantal ethics strongly challenges this current situation.

Society in particular medical situations must be challenged to answer not just what it wants (goals) but what it *ought* to want. This is the responsible covenantal ethical question. It is not just a question of resource allocation, as it is so often phrased today, but it is a deeper, more inclusive question of what one ought to want in terms of health and in light of a

³⁰Truog, Brett, and Frader, 1561.

wholistic understanding of body-self. In such a framework, more medical technology thrown at a physical illness may not be the answer, not because it is futile but because it doesn't achieve the goals that come from the radical faith and understanding of what life is -- individually and communally.

Can this be done? Yes! Attempts at it have been made through such things as advanced directives and living wills. Often, however, the public has seen these as an adversarial step to stop medical technology. The covenantal ethic invites a more inclusive dialogue to arrive at goals inclusive of scientific technology and publicly perceived good. As dialogues are already taking place on the scale of physician and patient regarding a patient's best interests in a particular situation, it is not too much to imagine a dialogue on a larger scale that can establish the goals of best interest in the area of medical intervention.

A Case Study - Hilga Wanglie

The Case

On December 14, 1989 Hilga Wanglie fell and broke her hip. This injury led to successive treatments at a series of acute care, rehabilitation and nursing facilities during which she had several cardiopulmonary arrests. For more than a year (May 23, 1990 to July 4, 1991, when Mrs. Wanglie died) she was unconscious and in a persistent vegetative state sustained by a respirator and nasogastric tube. Mrs. Wanglie's physician finally concluded that further treatment would be "non-beneficial" and "medically

inappropriate,"³¹ and sought to remove the life support. Oliver Wanglie, the patient's husband, would not give permission on the (disputed) grounds that his wife had expressed her desire not to have her life shortened. A petition was filed by Steven B. Miles, a gerontologist at the Hennepin County Medical Center (HCMC), to have the court replace Mr. Wanglie as guardian of his wife so that medical treatment could then be terminated. On July 1 the court denied the petition, finding no reason why Mr. Wanglie could not act a conservator for Mrs. Wanglie.

Commentary

In some ways this case is a helpful one to consider the issue of futility in that there are no conflicting issues such as lack of financial resources (Mrs. Wanglie's insurance company would pay for the continuing treatment) or the need of the equipment for other patients. These factors make it easier to focus on futility as the main issue.

In another way this case provides confusion over the understanding of futility and the questions of who defines it and how. This, however, is a very typical feature of cases where futility is an issue and will help to focus on one of the strong pleas from covenantal ethics for more open and full consultation in such cases before pronouncements of futile are made if, in fact, it is useful to make them at all.

³¹Veatch and Spicer, 21.

One of the pleas from Clinical Ethics is to separate effect from benefit. In this case, this is a key distinction with the problem being there was no clear differentiation between the two. Clearly the effect of continued medical treatment would be to sustain physiologic functions but the petitioners at HCMC equated this with "no benefit" while Mr. Wanglie saw this effect as beneficial. Who decides? The physician in this case had presumed the benefit and apparently either did not know or dismissed the values of Mr. Wanglie who saw benefit to sustaining physiologic function. In such a scenario the final judgment can not be that treatment is futile. Covenantal ethics might agree that there will be no net medical benefit and Jecker and colleagues might urge a pronouncement of medical futility at this point, but the medical outcome should not be the only factor considered in the indications for medical intervention nor for determining futility. Benefit can not be determined by clinical data alone, especially if it is truly to be a judgment of *net* benefit and, most important, when there are other persons within the patient's covenantal community to be considered in what is *net* benefit.

Regarding the distinction between quantitative and qualitative futility, the discussion is similar to above with the added question of the worth of making such a distinction at all. On the one hand, the distinction in this case would have clarified the viewpoints of the HCMC and Mr. Wanglie, but it would not have led to resolution. There is a danger in the approach of

Schneiderman, et. al., in advocating so strongly that the physician has the authority over determinations of quantitative futility while qualitative definitions are left to an amorphous "other." The danger is illustrated clearly in Wanglie -- the physicians can play quantitative futility as some kind of trump card.

A covenantal ethics approach, if this case could be replayed, would define a very different process and tools by which the decision for treatment or nontreatment could be made. The cornerstone of this approach is responsibility, which means the commitment to full and open consultation. It is astonishing that HCMC could hold Mr. Wanglie accountable for not knowing Mrs. Wanglie's definitive wishes about life support and termination of same, and then not hold themselves just as accountable for not knowing when, for the first four months of 1990, Mrs. Wanglie was competent to express her wishes and was under their care in their hospital.³² Open consultation begins early in a physician and patient relationship and it clearly includes the establishment of values and the sharing of those by both parties. As particular medical situations arise (at the time of Mrs. Wanglie's first cardiopulmonary arrest, for example) discussion of values must be revisited and applied to options in the new situation.

³²Alexander Morgan Capron, "In Re Hilga Wanglie," Hastings Center Report, September/October 1991, 26.

As this case progressed, even failing the conversation in the initial months of hospitalization, the conversation with Mr. Wanglie should have provided the opportunity to discuss the value that would lead to decisions about true benefits in the eyes of those involved defined far more inclusively than just by clinical data. It is apparent in this case that even the consensus of medical opinion as to what is futile and what is net benefit does not include all of the information to make a truly complete judgment.

Summary

It is questionable whether medical futility is a useful concept in determining medical treatment. The frequency of its use, particularly in end-of-life decisions does highlight, however, important issues for covenantal ethics in the area of medical indications. What has been stressed here is the importance of being open about the reality that clinical data also have values attached to them, that the authority of the physician in treatment is a shared authority and not a unilateral one, and that a covenantal ethic calls for the inclusion of a broadening circle of community (depending on the circumstances) in making decision regarding the *net* benefit of medical intervention.

CHAPTER 4

Autonomy and Covenantal Relationships

Introduction

This chapter examines the ethical principle of autonomy. It has been and continues to be a primary principle in ethical decision making and has been used, in recent decades, as almost a "trump principle" that puts all other principles in a secondary position of consideration. The first section examines the use of this principle in Clinical Ethics, which views autonomy as an important principle that counteracts unjustified paternalism. At the same time, autonomy does not have a priority position over the other ethical principles. The next section explores the definitions and applications of autonomy relevant to this study, primarily using the work of Beauchamp and Childress but supplementing with other writers where helpful. The third section of this chapter discusses the principle of autonomy and covenantal theology as a way of refining the use of this principle in a covenantal ethic. In the final section a case study will be presented to examine in detail some of the applications of a covenantal ethic approach to autonomy.

Autonomy and Clinical Ethics

Autonomy is an ethically significant principle because it emphasizes the importance of the patient's preferences in their treatment. Not only is this important for the respect of the patient's wishes but it is also integral to the success of medical treatment in most cases. There are, however, many

situations which in the clinical setting affect the autonomy of the patient. Some of these will limit the autonomy of the patient while others may prevent the paternalism of medical treatment. It is in those situations when discord occurs between the physician's preferences and medical judgment and the patient's preferences that there are genuine ethical concerns and dilemmas. Clinical Ethics reviews each of these situations and gives its counsel.

Competence and Capacity to Choose

For patient preferences to be respected, the patient must be informed and competent. But the meaning of competence is often unclear. "The clinician must recognize how to assess for practical purposes whether a patient is competent to formulate and express preferences and whether such preferences fall within range of preferences generally comprehensible to others."¹

Competent and incompetent patients differ in their ability to understand and communicate information, to set goals and values and communicate them clearly, and in their ability to reason about their choices. Determining between the two can be a perilous task for the clinician and the advice of Clinical Ethics is to use all of the tools available commensurate with the circumstances. This includes outside psychiatric consults,

¹Jonsen, Siegler and Winslade, 52.

knowledge of the patient's past preferences, and expressions from close family members and friends regarding patient preferences if there is any doubt about the competence of the patient to comprehend treatment options. The level of competence required to consent or refuse a certain treatment will also depend on the nature of the particular treatment. "For example, a patient might need only a low level of capacity to *consent* to a procedure with substantial, highly probable benefits and minimal, low probability risk, but a high level of capacity to *refuse* the same treatment."²

The authors also speak to cases where a patient's beliefs may lead to refusal of treatments when, in the physicians' view, a competent person would not refuse them. In such cases physicians are cautioned against using unusual beliefs as an indication of incompetence. Such holding to unusual beliefs by a patient is not in itself evidence of incompetence or incapacity.

Informed Consent

Part of the competence of the patient depends on adequate information to make decisions. Such information is often called "disclosure." Disclosure of information is adequate if it allows "reasonable persons to make prudent choices in their behalf."³ The physician must then be careful to present

²Jonsen, Siegler, and Winslade, 59.

³Jonsen, Siegler, and Winslade, 62.

information to the patient in such a way that it can be comprehended and an informed consent given or refused.

There are circumstances when the physician may decide that some information would be harmful for a patient and thus it is withheld, as in the case where a physician would judge that a patient is not "able to dispassionately weigh the risks of refusing to undergo [a] recommended treatment."⁴ These cases are the exception, however. It is generally advised that the physician try in as many ways as it takes to be certain that the patient is adequately informed so as not to compromise their autonomy. This includes truth telling and complete disclosure of the information regarding treatment, including "the options which the physician recommends and also other options which the physician may believe are less desirable but which are still medically reasonable."⁵

Refusal of Treatment

When a patient has the capacity to choose and refuses treatment, there is a tension for the physician between paternalism (doing what the physician thinks is best for the patient) and the patient's autonomy. It is a conflict between two ethical principles: respecting the patient's wishes (autonomy) and benefiting the patient (beneficence).

⁴ Jonsen, Siegler and Winslade, 65. The authors cite case law (Cobbs v. Grant, 1972) to suggest this standard.

⁵ Jonsen, Siegler, and Windslade, 68.

A patient may refuse treatment for many reasons. The issue for the physician is to determine if the refusal is competent refusal. If it is, then the physician has little ethical justification for overriding that refusal. If, however, there are reasons to be suspect of the refusal or, if the consequences will bring harm to others, the physician may have grounds for acting paternalistically and treating the patient with the refused treatment. The authors express reservations about this overriding of refusal, however, and recommend several options to be sure that all methods, short of coercion, have been tried to obtain a competent consent to treatment.

Another form of refusal of treatment is noncompliance with treatment. Like overt refusal, noncompliance may also be a patient behavior for many reasons. In some circumstances the physician may have a personal negative reaction to patients who consistently do not follow their prescribed treatments. There may also be issues of abuse of the medical system which enter the picture as a person has repeated hospitalizations, thus using health care resources, all of which could be prevented if the patient would follow the prescribed treatment. Such cases may intensely involve of the physician to the point where he/she feels they must withdraw from the case. The authors again cite several scenarios that have these dynamics. The summary advice is to obligate the physician to educate and persuade the person to follow the prescribed treatment. This advice is not given lightly. In the scenarios used to illustrate cases of this type, the authors show how difficult it is and how

important it is for the physician to, as much as possible, put his/her own feelings of frustration or hurt or anger aside in order to persuade the patient to follow their prescribed treatment. The authors thus place a high value on autonomy. Even the autonomy of the "problem patient."

Summary

Autonomy of the patient is of such value that the physician may, at times, be asked to put his/her own moral position on hold. This is a troubling aspect of care for covenantal ethics and in the best of all possible relationships this would not be the case. Autonomy is still too often used as a trump card by patients who want their own way or by health care workers who, trying to guard against paternalism, may cause problems of justice while protecting the patient's autonomy.

Covenantal ethics is concerned with the balance of principles (as are the authors of Clinical Ethics). To gain a better understanding of the ethical principle of autonomy and how one might approach some of the dilemmas caused when it conflicts with other principles, the next section takes a look at the foundations of this principle in ethics.

The Ethical Principle of Autonomy

Historical Development

In classical history, autonomy is a Greek term referring to self governance in Greek city-states (autos=self; nomos=governance or law). In

this sense it might be defined as "personal rule of the self by adequate understanding while remaining free from controlling interferences by others and from personal limitations that prevent choice."⁶ The Greek culture thus gave to civilization an understanding of self-rule which placed individuals in the midst of their societies with a right to make certain choices that impacted one's life and to make them free of controlling influences. In this framework there were two determining factors as to whether one was indeed acting autonomously: (1) freedom from external constraint; and (2) critical internal capacities that enabled one to make choices for self-governance. The ability to make these choices was crucial to being autonomous.

In 1859 John Stuart Mill published his important paper on autonomy called "On Liberty."⁷ Mill stresses the importance of choice free from outside influences. Even though he does not reject the importance of culture or tradition or community, he resists strongly any enslaving influence by any of these over one's freedom to choose. For Mill, there are three conditions for liberty:

1. inward domain of consciousness or liberty of thought and feeling.

⁶Tom L. Beauchamp, Philosophical Ethics, 2nd ed. (New York: McGraw-Hill, 1991), 385.

⁷See John Stuart Mill, "On Liberty," in Collected Works of John Stuart Mill, vol. 18 (Toronto: University of Toronto Press, 1977), as cited in Beauchamp, 393-395.

2. liberty of tastes and pursuits or the freedom to develop and follow one's life plan.
3. liberty of combining individuals or the freedom to unite.⁸

For Mill "the only purpose for which power can be rightly exercised over any member of a civilized community, against his will, is to prevent harm to others."⁹ Otherwise, Mill would argue, autonomy is such an important value that interference is not advocated even if interference is for the person's own good. In this regard, Mill gives the illustration of a person who is about to walk across a bridge that they do not know is washed out. Mill would allow that one may interfere with the person's autonomous decision only in so far as informing the person that the bridge is washed out. If the person decides to continue across the bridge, the ethically correct response is to respect the person's autonomy and let them go. The reasoning is that no one can know what is truly "good" for another person; therefore, autonomy is to be respected as one of the highest order of values.¹⁰

By the 1970s a new wave of emphasis on autonomy was felt. In American society in general, any authority was resisted as infringing on personal freedoms. One area, among many, where this was keenly felt was medicine.

⁸See John Stuart Mill, "On Liberty," as quoted in Beauchamp, 394.

⁹See John Stuart Mill, "On Liberty," as quoted in Beauchamp, 393.

¹⁰See Beauchamp, 386 and 419-20 for a more thorough discussion of Mill's bridge illustration.

The medical profession had been practicing a kind of paternalism where it was assumed, by both patient and physician, that the physician knew what was best for the patient. In the '70s this presumed authority began to be challenged. The Hippocratic maxim to benefit the patient did not mean, so said the autonomy advocates, that the physician had the sole right to define what it was that would benefit the patient. Along side of society's challenges to authority was the development of medical technologies which both enhanced and threatened a patient's autonomy. Amniocentesis, for example, brought women demanding to know the condition of their fetus even if the physician thought it best for them not to know. Terminally ill patients demanded to be free of new medical technologies and be allowed to die naturally. "We discovered that never in the history of professionally articulated ethics had there ever been any acknowledgement of the patient as a dignified agent free to participate in and exercise self-determination over medical decisions."¹¹

The pendulum had swung the opposite direction. Now it seemed, at least in medical decisions, that autonomy was the primary principle. It had become the new trump card even overriding Hippocratic beneficence.

¹¹Robert M. Veatch, "Autonomy's Temporary Triumph," Hastings Center Report, October 1984, 38.

Adequate Autonomy

Autonomy is an odd concept. It is a goal toward which people strive, which never actually exists. No one is, or can be, truly autonomous -- especially in the absolutist sense in which the word is often employed.¹²

As Cassell states above, absolute or pure autonomy is a myth. Even if it were possible for an individual to be isolated from all influences at the time of a particular choice or decision, that individual's choices would still be influenced by cultural, family and religious traditions and mores that have been a part of his/her past as well as the current context in which he/she will make the decision. Thus, one must distinguish, in evaluating autonomous choices, between an ideal of absolute and pure personal autonomy, which is an unattainable myth, and a respect for personal autonomy which is achievable and an ethical goal to be sought.

The Tests of Adequate Autonomy

The test of the autonomous person. First, autonomous choices are made by autonomous persons and, autonomous persons are "competent, informed and act voluntarily."¹³

Competence is always a concept of continuum: a person is always more or less competent. For example, "an experienced and knowledgeable patient

¹²Eric J. Cassell, "Life as a Work of Art," Hastings Center Report, October 1984, 36.

¹³James F. Childress, "The Place of Autonomy in Bioethics," Hastings Center Report, January/February 1990, 13.

is likely to be more competent to consent to a procedure than a frightened, inexperienced patient in the E. R."¹⁴ Further, a person is not competent or incompetent in all areas of life. It is, thus, a contextual standard as well as a relational one.

The conflict over competence often arises when a person is making a decision that will likely bring harm to the individual. It is here when the principles of autonomy and beneficence are in conflict. It is important in such instances to see the conflict as an issue of conflicting ethical principles and not an issue of a patient's competence. A patient may be competent and even make a decision that would lead to self-harm; nevertheless, the patient is fulfilling the standard of competence. Patient "Y," for example, wishes to be taken off of a respirator -- an act that will certainly lead to her death. She makes her decision with full knowledge of the consequences and is not clinically depressed. It is her judgment that the quality of her life is severely diminished to the point that her death would be better than her life. In this case, patient "Y" is competent and, therefore, fulfilling this test of autonomy even though the result of her decision will bring her death -- a result others might judge as "harm." The actions that others should or should not take in such an instance are a matter of resolving the conflict in ethical principles, not a matter of competence.

¹⁴ Beauchamp and Childress, 81.

To be informed, the second test of autonomy, a person must have and act on all pertinent information necessary for a particular decision. In the example of patient "Y," she must know the results of discontinuing the respirator, and the available medical alternatives, if any plus her prognosis for her future condition.

To act voluntarily, the third criterion, a person must make a conscious and unencumbered choice. As indicated above, patient "Y" has been judged to not be clinically depressed, a diagnosis which would cloud a judgment of whether she could make a truly voluntary decision. If she is not coerced by others into this decision or other actions that would preclude a voluntary decision, then, she is acting voluntarily. The person, then, judged competent, informed and acting voluntarily is an autonomous person.

The test of autonomous choices. Autonomous choices are made by autonomous persons who "act (1) intentionally, (2) with understanding, and (3) without controlling influences that determine the action."¹⁵

A new term needs to be introduced to more accurately describe what is meant by autonomy as an alternative to an ideal of personal autonomy. The term is "adequate" or "substantial" autonomy. Adequate autonomy is judged by the degree to which the above factors of autonomous choices are fulfilled.

¹⁵ Beauchamp and Childress, 69.

The first factor, intentionality, can be demonstrated by the planning that has gone into a particular decision and the consistency of that plan. Intentionality, therefore, is not so much a matter of degree but of foresight and consistency.

"Understanding" and "without controlling influences," the second two criteria of autonomous choices, are a matter of degree. "Actions can be autonomous by degree, as a function of satisfying these two conditions to different degrees."¹⁶ One's understanding of the factors involved in a decision may be partial but enough to feel comfortable with making a decision. So, if one is making a medical decision regarding treatment, one may need to know the kind of treatment recommended, the possible risks and side effects and the anticipated benefits, but one may not need to know the chemistry of the drugs involved, for example. Thus, the person has sufficient understanding to act with adequate autonomy.

Similarly, a patient may need to know the stand of his/her church regarding the choice of abortion and may adequately, autonomously choose to follow that religious community's stand not as a matter of undo influence but as a matter of free choice.

This last factor of the degree to which outside influences bear on one's decisions to still declare them adequately autonomous needs further

¹⁶ Beauchamp and Childress, 69.

amplification. Persons may be autonomous, act intentionally and with understanding but put their lives under the influence of another. This is a common situation in the relationship between a patient and physician, where a patient can "yield their first-order decisions (that is, decisions about the rightness or wrongness of particular modes of conduct)"¹⁷ to the physician to decide the best mode of treatment. In this case, the physician respects the person's autonomy by giving him/her all the information needed and treating the patient to the best of the physician's own knowledge and ability, always holding open the option for that patient to refuse treatment or take back the right for the physician to decide on treatment options in the future.

Autonomy and Authority

Immanuel Kant (a deontologist) and John Stuart Mill (a utilitarian) both were concerned with the relationship of persons to authority and, although coming from different theoretical points of view, agreed on dramatic constraints on authority over autonomy.

Kant advocated the individual worth of persons with the capacity to determine their own destiny. It was, for Kant, a violation of another's autonomy to exert one's authority and treat them as a means to an end without any consideration of their goals or wants.

¹⁷Childress, 13.

Mill was specifically concerned about the authority of governments over people. A person with character, for Mill, remains an individual with values and beliefs formulated by him/herself. A person without character allows an authority to formulate his/her beliefs and values for them.¹⁸ Mill says, "The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others."¹⁹

The issue between autonomy and authority is one of control. If one freely chooses to yield one's decisions to an authority, one is acting autonomously. However, if an authority exerts power and influence over another against that person's free will or somehow compromises the freedom of the individual's will, then that person's autonomy is compromised. The question is one of influences used properly or improperly by an authority over an autonomous individual.

It is important to state at this point that this third factor in determining if an action or decision is truly autonomous is that it is without controlling influences that determine the action. This is not to say that there can be no influences on an adequately autonomous person. There are, in reality, many influences on any decision or action. What must be avoided is *controlling* influences by another if one and one's actions are to be autonomous. To help

¹⁸Beauchamp and Childress, 392.

¹⁹Beauchamp and Childress, 393.

evaluate if influences are controlling in a compromising way, one might classify influences into three categories: coercion, manipulation and persuasion.

"Coercion occurs if one person intentionally uses a credible and severe threat of harm or force to control another."²⁰ Coercion completely compromises autonomy. Although the same threat may seem as a threat which will force an action by one person and not seem so by another, coercion exists when the threatened takes an action because of a threat by another which otherwise would not have been made or chosen.

At the other end of the scale of influences from coercion is persuasion. Persuasion is the influence by which one is "convinced to believe in something through the merit of reasons advanced by another person."²¹ Both persuader and persuaded must find that a particular conclusion is warranted by the evidence. If persuasion is to respect autonomy, the persuader's purpose is more to give supportive evidence for a particular conclusion so that the persuaded will see the wisdom behind it and freely choose the same reasoning and come to the same conclusion. Conversely, if the persuader uses false or distorted evidence in order to force or control another's conclusions and actions, then persuasion has crossed the line into

²⁰Beauchamp and Childress, 107.

²¹Beauchamp and Childress, 108.

not respecting the other's autonomy and, if the other did, in fact, choose the alternative based on this improper use of persuasion, then the person would not be judged as having made an adequately autonomous decision.

Finally, manipulation refers to a whole class of influences.

"Manipulation is getting people to do what the manipulator wants by means other than coercion or persuasion."²² The above example of improper persuasion could, perhaps, be more accurately classified as manipulation. Since manipulation, in all cases, seeks to exert control over another's actions and decisions, it also compromises autonomy.

It is a truthful assumption that influences are a given in any decision that one makes, particularly where one is in relationship with an authority (i.e. one's physician, teacher or church). This being the case, the concern in determining if one is acting autonomously is to determine at what point an influence becomes controlling of one's will and thus one becomes less than free to choose. This point will be difficult to define at times and is perhaps mostly in the mind of the beholder. It would be possible, for example, for one individual to respond to an authority's influence in making a decision and to judge that they have acted adequately autonomously. Another person, standing on the outside of this relationship, could judge that the authority has exerted undue control because, perhaps, the outsider uses different

²² Beauchamp and Childress, 108.

measures of evidence. Thus, the outsider could judge that the individual has not acted autonomously.²³

The standards, then, that are important by which one can judge if an action is autonomous in so far as influences are concerned, is the measure of control. If an authority's motivation is control over the individual, and if the authority uses coercion or manipulation, even if justified by the yardstick of doing it for the other's own good, this kind of influence compromises the autonomy of the individual.²⁴

Autonomy and Community

A major part of the influences on autonomous individuals comes from the communities to which the individuals belong. To varying degrees these communities will have an impact on one's decisions and actions.

The use of authority and of one's freely yielding first and second order decisions plays a major role in the dynamics between autonomy and community. John Stuart Mill argued that all cultural influences should be rejected. The person without character, thought Mill, does not choose, does not develop, his or her own beliefs and values, and does not exercise his or

²³This distinction becomes crucial as we begin to consider, as we will later, the role of the church and one's faith in making decisions.

²⁴"For another's own good" is a difficult reason to apply. For a more complete discussion of the issue, see the section on "Paternalism" in this chapter (pp. 116-21) or the work of Beauchamp and Childress and others cited in the paternalism section (pp. 118-20).

her precious and distinctive mental facilities: "Character is formed for him and not by him."²⁵ Mill's argument is perhaps best heard as a caution against an individual completely abdicating decisions and values to a community. To argue, however, that one's own values and beliefs come, or should come, independent of any culture or community would be going beyond reason and against experience and was not Mill's intention. In fact, as Gustafson argues: "We need not be the prisoners of a given culture or society in the modern pluralistic and mobile world."²⁶ We are a part of many cultures and communities in our lifetime and our decisions will be influenced by them all to lesser or greater degrees over our lifetime and depending upon the particular situation.

Our autonomy, in reality then, is never an isolated concept but is always in relation to community. We must respect persons not merely as individuals but as "members of one another in their communities."²⁷ The question then is, what role does community play?

²⁵Beauchamp, 392.

²⁶See James M. Gustafson, "Agency and an Interactional Model of Society," in Theology and Ethics, vol. 1 of Ethics from a Theocentric Perspective (Chicago: University of Chicago Press, 1981) reprinted in On Moral Medicine, eds. Stephen E. Lammers and Allen Verhey (Grand Rapids: Eerdmans, 1987), 293.

²⁷Gustafson, as cited in Lammers and Verhey, 294.

Relationship of the Autonomous

Individual to Community

First, one must agree that the relationship in fact exists! If the point of moral autonomy is to protect an individual from others by empowering their individual liberty and restricting that of others on them, then this autonomy can be gained at an extreme price -- the price of isolation from community.

It establishes contractual relationships as the principle and highest form of relationships. It elevates isolation and separation as the necessary starting point of human commitment. It presumes that the moral life can be made a wholly voluntary matter (at least for that much revered figure, the 'consenting adult'), thus attempting to deny the validity of many uninvited moral obligations that ordinary life with other people usually casts before us. It will inevitably diminish the sense of obligation that others may feel toward us, and shrivel our sense of obligation toward others²⁸

For most, this price is too high and thus, they willingly enter into obligations and relationships which will restrict their absolute autonomy. People get married, have children, join churches and become part of civil communities, and each commitment to community places them in a position of give and take regarding their own autonomy. For most, the benefits far outweigh the losses.

One of the benefits of community is to bounce one's autonomous decisions, ideas and values up against others. In this way, one is better able

²⁸Daniel Callahan, "Autonomy: A Moral Good, Not a Moral Obsession," Hastings Center Report, October 1984, 41.

to judge the value and validity of one's decisions. The community acts as a sounding board and check against decisions that may be arrived at solely through the narrow judgment of the individual's experience. Thus, the individual's perception of a particular problem can be influenced by his/her culture and community but not at the sacrifice of his/her autonomy.

Second, after a decision is autonomously reached, the individual may check his/her decision with others in the community before the action is taken.

Third, the individual may need and request the involvement of others in the implementation of the decision, either as support or in actually carrying it out.

Finally, the individual may use the community for evaluation -- a review for the sake of learning from the experience to aid in future decisions.

These options illustrate how the adequately autonomous individual may use the community without sacrificing being adequately autonomous.

Another relationship between the autonomous person and the community involves *obligations* the individual has to the community. Perhaps this can be aptly illustrated by the contemporary issue of HIV infection. There has been much discussion surrounding the freedom of individuals (autonomy) infected with HIV positive antibodies to practice medicine or continue to have sexual partners without telling their partners of their infection. To argue, on the basis of respect for autonomy that the

infected individual is free to choose to live the same lifestyle as before infection again purchases autonomy at too great a price -- this time, however, the price is paid by the community. The obligations one takes on as a part of community can restrict some freedoms and liberties. It could even be argued, in the HIV example above, that: "The needs of the community in public health may well override the rights related to the principle of respect for autonomy of some individuals under some circumstances to reduce the spread of HIV infection."²⁹ Thus, the reality of the relationship of the individual to community brings some benefits to one's autonomy and also some obligations that may even restrict one's autonomy.

The Relationship of the Community to the Individual

Any relationship is a two-way street by definition and, therefore, to complete the discussion of the place of the individual's autonomy with relation to his/ her community, we must also consider the relationship of the community to the autonomous individual.

First, it is important to recognize that the community, in a healthy relationship with its members, is an advocate and supporter of the principle of the respect for autonomy. In fact, in the responsible community that Niebuhr envisioned, the respect for autonomy is so closely tied to the value of

²⁹Childress, 16.

the "common good" that each contributes to the other. Thus, to support the autonomy of its members, the community also contributes to the common good because the members autonomously choose to contribute, in action and decisions, to the common good.³⁰

Daniel Callahan asks: "Does a respect for autonomy mean that we are not allowed to imagine a good for others beyond that which they can imagine for themselves? Or that we are not allowed to persuade others that their autonomous moral choices are wrong or defective or less valuable than they might be? Of course we are allowed to do these things."³¹ In this question and answer Callahan points to a valuable role of the community with the individual; that is the role of moral standard and moral visionary. With all the cautions against coercion elaborated above taken into account, this is an important role of the community. Indeed, it may be an obligation of the community to provide the moral standard by which autonomous individuals make their decisions and to provide a collective vision of a better moral community toward which contemporary decisions strive.

³⁰For a pertinent caution on this idea see Callahan, "Autonomy," 42, where Callahan argues: "There can be no valid community unless its citizens have some sense of a common good. . . . Despite what supporters say, an emphasis upon autonomy does seem to gut a mutual seeking of a common good. Indeed, there is no such thing as a 'common good' under a reign of autonomy; there is only the aggregate of individual goods."

³¹Callahan, "Autonomy," 41.

Another very important role of the community to the individual is one of advocacy on behalf of those who are not adequately autonomous. This can be stated by saying that the community balances the moral principle of justice with the principle of respect for autonomy. For the members of the community who are handicapped, ill or unable to speak and express their own autonomous choices, the community acts as advocate. This can be a very delicate balance of principles indeed as illustrated in the issue of abortion where discussion speaks to the rights of the fetus vs. the rights of the mother. The community does have a valuable role in being an advocate for the fetus. However, where the role oversteps its bounds is when the mother's autonomy is completely discounted in favor of the fetus. Such a situation is not the proper role of the community. The *proper* role is one of *balancing* of moral principles, not usurping one for another.

In summary, the relationship between the autonomous individual and the community and vice versa can be a supportive one to autonomy as well as a healthy corrective.

The Problem of Paternalism

There are a number of autonomy limiting principles that have been proposed in recent philosophical controversies. Four of these principles are:

1. *The Harm Principle*: A person's autonomy is justifiably restricted to prevent harm to others caused by that person.
2. *The Principle of Paternalism*: A person's autonomy is justifiably restricted to prevent harm to the person caused by that person, irrespective of whether harm is caused to others.

3. *The Principle of Legal Moralism*: A person's autonomy is justifiably restricted to prevent that person's immoral behavior, irrespective of whether that person's conduct is harmful or offensive.

4. *The Offense Principle*: A person's autonomy is justifiably restricted to prevent hurt or offense³² (as contrasted to harm or injury) to others caused by that person.

It may be possible to argue that a community could positively or negatively use any of these limiting principles at times. Therefore, if one is going to interfere with another's autonomy, it should be done only with the greatest care and caution. For, as we have seen, the respect for the individual and their importance calls for the community to respect the individual's autonomy as much as it calls for individuals to take the community into consideration in their autonomous decisions and actions. Therefore, any autonomy-limiting principles such as paternalism, which will be discussed here, can be used for good or ill. On the one hand, they can be used to enforce a balance and consideration of competing ethical principles. On the other hand, they can be restrictive and disrespectful of a person's identity, spirit and autonomy.

In medicine, four historic factors led to the call for autonomy over paternalism:

1. Physicians performed experiments on people with out their consent.
2. Physicians performed therapeutic procedures for patients' own good with out consent.
3. Certain features of modern medicine are depersonalizing.

³²Beauchamp, 389.

4. Through the use of science and technology, physicians have gained an enormous amount of power.³³

The stress on autonomy that has resulted from these factors has made a positive contribution to the practice of medicine, but perhaps, the pendulum swung too far and there has resulted, in the '70's and '80's, an attitude of selfish individualism that needs a corrective. Autonomy-limiting principles such as paternalism, correctly and carefully applied, can be such a corrective.

"Paternalism is best defined as autonomy limitation in which the person who limits autonomy appeals exclusively to grounds of protection for the person whose autonomy is limited."³⁴ In short, paternalism places the ethical principle of beneficence over the principle of autonomy. In taking paternalistic action there is little conflict if the person is of diminished autonomy in the first place (i.e., ill, unconscious, mentally incompetent, etc.). The conflict comes when one interferes with another when the other's autonomy is intact!

Mill, a strong opponent of paternalism, argued that interference with another's autonomy can only be done to ensure that a person's autonomous decisions are voluntary and informed. He uses the illustration of a person about to cross a bridge that has been washed out. Mill argues that one can

³³Lammers and Verhey, 273.

³⁴Beauchamp and Childress, 412.

only interfere to tell the person that the bridge is washed out. Once that is done, the person should be free to cross the bridge even at their own peril. Robert Veatch goes even further in the area of medicine to say, "Respecting the patient's autonomy always takes precedence over benefiting the patient against the patient's autonomous will."³⁵

These cautions and others are sufficient to summarize the point that paternalism can be improperly used and, therefore, be a negative and unjustifiable infringement on another's right to autonomy. Are there then, positive uses of paternalism?

It is the contention here that paternalism can validly be used to limit another's autonomy when two conditions are present:

1. There is a good that one can see for another whose autonomy will be limited; and
2. There is a covenant that bonds the person and the one who is doing the limiting of that person's autonomy.

Traditionally, one strong objection to paternalistic action is the challenge that it is perhaps impossible for one person even to know what is truly good for another.³⁶ The above two conditions take this objection seriously. The only guarantee that one could have such knowledge of what is

³⁵Veatch, 38.

³⁶For a complete discussion of this viewpoint see Joel Feinberg, Harm to Self (New York: Oxford University Press, 1986).

good for another would come through a pre-existing covenant built not just on a mutual agreement of persons, but one that encompasses a body of commonly held beliefs -- beliefs held over time and centered, not in oneself or selves but in a covenant history that transcends the contemporary moment and time. With a covenant existing between persons, there is not an absolute guarantee but certainly a high probability that one's judgment of "the good" for another will, in fact, be a valid judgment. At the very least, paternalistic interference under such conditions will cause the person taking an action to reflect with new information and either be even more certain of the correctness of the action or autonomously change the action based on the other's vision of "the good."

What "the good" is, is a situational thing but by definition of the functioning of the covenant community elaborated above, "the good" will be a conscientious balancing of the ethical principles involved within the covenant of God's love and history.

In his article on autonomy, Daniel Callahan closes with a plea for such a covenantal community to help define "the good." It is worth quoting here at length.

I have been told for nearly fifteen years that I should have the right to die when and as I choose. But hardly anyone talks about how I should measure my own value to myself and to others; and thus when I should want to stop living. I have been told that I should freely choose the number and genetic quality of my children; and that I have a right to a perfect child. But the notions of perfection that abound sound more appropriate for judging the worth of stereo

sets and food processors than human beings. I have been told that I should be able to choose between a longer life and a higher quality of life. But precious few people write thoughtfully on what constitutes a decent quality of life. Most items I see on the subject make it sound as if the capacity to get a high score on the SATs is the name of that game. But surely there must be better standards than that.

I am, finally, told that I have the right to fashion my own moral life and shape my own moral goals. But how do I go about doing that? No one is saying. Yet I am certain that I cannot do it alone. My autonomy, I have discovered, is an inarticulate bore, good as bodyguard against moral bullies,³⁷ but useless and vapid as a friendly, wise and insightful companion.

Covenantal theology is a theology of the responsible community that helps form and inform one's autonomy. This study now turns to some of the detail of how this works.

Autonomy and Covenantal Theology

To find the cultural roots of autonomy, according to Robert Veatch, "some trace them back to Adam. Certainly they are in the right tradition -- with the Judeo-Christian notions of covenant, commitment and conversion. By the 16th century, especially in the left wing of the Reformation, the concept of the individual as a free, choosing person was emerging full-blown."³⁸

As Veatch points out, with the notion of covenant, the biblical idea of autonomy begins with a relationship. The Hebrew post-exodus writer wrote, in the creation narrative, that the true identity of the individual is found as

³⁷Callahan, "Autonomy," 42.

³⁸Veatch, 38.

he/she enters into relationship with God. Indeed, there is no such thing as autonomy if translated as self-governing means apart from and outside of the covenantal relationship with Yahweh expressed in the Law. One is truly autonomous only when he/she is in a righteous relationship to God and to each other in the covenant community. The Law, in this context, is a gift which gives the covenant member the governance to follow by autonomous choice. When this choice is made, both the individual and the community are strengthened and truly reflect the image of God intended at creation and the covenant community is fully realized. The "fall" of the first human beings serves to illustrate what the Hebrew writers observed in their own time: that human beings choose to follow their own autonomy and become self-governing rather than choose to follow the Law and be a part of a covenant community.

The apostle Paul reflected on this reality and concluded that the "fall" meant that human beings cannot always know and do what is right by their own free choice. By "nature," said Paul, people are slave to sin (Rom. 6:17-20). Calvin, during the Reformation, reading Romans and evaluating secular society, held that "the human state is so debased that not even good prudential reasoning is possible. Only external coercion and institutionalized constraints suffice to keep us from self-destruction."³⁹ A

³⁹Robin W. Lovin, "Equality and Covenant Theology," Journal of Law and Religion 2, no. 2 (1984): 246.

society which institutionalizes such constraints is an affront to God's created human freedom, however. There must be another design that would be a safeguard against the human tenacity to put one's self in a position of ultimate importance and yet also allow the autonomy of free choice that God created "in the beginning." That alternative, for the Reformation writers, was the covenant community. This community, however, had to take into consideration the reality of the human spirit and that produced some tension.

Greek and Pauline Autonomy

As noted earlier, the word autonomy came from the Greek meaning "self-governance." It is based on a foundational belief that individuals are capable of making choices and therefore governing themselves. Paul would not argue against the idea that humanity can make choices, but he would take issue with the idea that humanity, left to its own, can make correct choices. For the apostle Paul, humanity's capabilities to make correct choices is severely affected by "the god of this world" (2 Cor. 4:4, NRSV). Paul recognized the tension that exists within himself: "I do not understand my own actions. For I do not do what I want, but I do the very thing I hate" (Rom. 7:15, NRSV). So strong is this conflict within that Paul concludes that it is an impossibility to be truly autonomous, for even one's choices are not one's own but are captive to sin. The Greek philosopher might define autonomy as freedom but for Paul it is just another form of slavery. "For Paul, one is slave either to sin or righteousness. One who claims autonomy

(self-law: auto + nomos) is really a slave to the law of selfishness/sin (Rom. 6:16-18; Gal. 5:13)."⁴⁰

The Meaning of Freedom

The difference between the two understandings of autonomy hinges on the concept of *freedom*. For Paul, the Christian faith gives one the freedom to be bound and yet, paradoxically, when one is bound to God in Christ, one is truly free: "But thanks be to God that you, having once been slaves of sin, have become obedient from the heart to the form of teaching to which you were entrusted, and that you, having been set free from sin, have become slaves of righteousness" (Rom. 6:17-18, NRSV). Autonomy, therefore, for Paul, is not a concept of isolation and independence but of community and interdependence, first a community with God and then a community with each other. "For you were called to freedom, brothers and sisters; only do not use your freedom as an opportunity for self-indulgence, but through love become slaves of one another. For the whole law can be summed up in a single commandment, 'You shall love your neighbor as yourself' " (Gal. 5:13-14, NRSV).

In Paul's model, the person of faith has the freedom to make choices but choices are not subjective. "We are under obligation to God (Rom. 8:12). Accordingly, moral living is a matter of faith in God and faithfulness to God"

⁴⁰ John F. Kilner, "A Pauline Approach to Ethical Decision Making," Interpretation 43 (October 1989): 374.

(Rom. 3:3-4).⁴¹ The Holy Spirit is God's gift through Christ that enables the individual to make these choices of obligation. Through the Holy Spirit, the mind of decision, which was once corrupt, is renewed and transformed and is able to recognize and obey God's will. Again, freedom of the individual is experienced only as one is tied to the Holy Spirit for the gift of a discerning spirit within.

Calvin continued to wrestle with this Pauline idea of freedom and particularly with the tension of free will choices as a person of a covenant faith. For Calvin, the safeguard of free will running amok was the covenant community. Indeed, Calvin expanded his theological concepts to design not only a faith community but a secular community as well. For Calvin, "genuine participation in society requires a dramatic change in one's thinking about it. This change includes an interest in the welfare of others."⁴² What happens, for Calvin, when one's concern and orientation becomes for and toward others is that the old nature of "self" is left behind. This is an important transformation indeed, for it goes to the very heart of how and why one makes choices. "In a covenant, it is the desires themselves which are adjusted, redirected onto the common good"⁴³ Thus, when

⁴¹Kilner, 369.

⁴²Lovin, 247.

⁴³Lovin, 247.

one enters a covenant, one is transformed into "a new creation: everything old has passed away; see everything has become new!"

Freedom is now redefined. Now one is free to be tied to God and in this covenant relationship one also becomes tied to others for the common good, a good defined by a righteousness with God and each other. One's autonomy is expressed at its best, when one freely chooses to be in covenant. "This God-centered focus, means, among other things, that neighbor-love respects God's intentions for the world."⁴⁴

Decision Making in the Covenant Community

The net result of entering into a covenant community is not a destruction of autonomy, but a balancing of this ethical principle with others, particularly the principles of justice and beneficence and the gaining of both a system of values and a community in which to make ethical choices.

When one's orientation shifts as a result of being in covenant with others, from "self" to "others," the principles of justice and beneficence take on greater weight. Justice, for example, requires that one see all members of the community as equals. "There is no longer Jew or Greek, there is no longer slave or free, there is no longer male or female; for all of you are one in Christ Jesus" (Gal. 3:28, NRSV). This means that even those who may be "least" in society are equals in the covenant community. This is particularly

⁴⁴Kilner, 377.

true of the powerless of society and of the "outsider." These are of special concern to the covenant community and actions are mandated by covenant community members on behalf of those who are powerless to act for themselves. Thus, Paul mandates to the covenant community care of widows and orphans, and Jesus teaches of the kingdom of God where the last shall be first. Justice, to the powerless, therefore, becomes a key principle of ethical decision making for members of the covenant community, and they are charged to constantly balance their autonomous choices with the needs for justice to others. Further, because people are equal in Paul's view, it follows that there should be equal access to such vital items as food and other necessities in order to live (2 Cor. 8:13). The principle of justice requires such distribution and treatment of others. In medical as well as economic arenas, this principle has a profound impact on the distribution of resources.

In similar fashion, the principle of beneficence takes on equal weight with autonomy in the covenant community. To do good (beneficence) is translated as the "Golden Rule" of the covenant community: "Do unto others as you would have them do unto you" (Matt. 7:12). Autonomy, to have my rights and choices respected, is therefore experienced as one gives others the same respect. Further, decisions that one makes in order to benefit oneself must also be made balanced with the benefit that the decision will bring or not bring to others.

Thus, one result of being in a covenant community is the balancing of ethical principles. Justice and beneficence become equals to autonomy in decision making. In any particular situation one value will be given more weight than another. It is in the evaluation of their weight that the covenant community also plays a role. This can happen in at least three ways.

First, the covenant insists that the context of any decision is not made in an isolated moment in history but in the context of God's continuing covenantal history. Decisions that are made have a past, in terms of the historic weight put on competing ethical principles; a present, in terms of the unique issues necessitating a decision now; and a future, in terms of the effect of the decision on the future history.

Second, the covenant provides a system of values with which to weigh ethical principles. Attempts have been made to express these values in one word, "love," while others (particularly Niebuhr) advocate a relational value theory. In either case covenantal ethics provides a value system upon which one can base one's ethical decisions.

Third, the covenant community plays a direct role in weighing competing ethical principles by providing the loving forum where one can make decisions. This forum may happen in formal or informal ways but the value is in the community that can bring to bear tradition and another perspective as one seeks clarification and eventual decision.

A Case Study: Autonomy and Faith Healing
in Childhood Leukemia

The Case⁴⁵

Within twenty four hours a 10-month old boy was transferred from a small local hospital to a university hospital and then to its affiliated cancer center with a presumptive diagnosis of leukemia. Because the diagnosis had not been confirmed by a bone marrow examination, information on the type of leukemia -- needed for an outline of a specific therapy and a more accurate prognosis -- was not available.

When the baby was admitted on a Saturday afternoon, only his mother was present. The child was not acutely ill, and the severe anemia that had concerned the referring physician had been corrected by transfusion before the transfer. The baby seemed much better, according to his mother. However, there were significant signs of tumor. [The therapy options for treatment could only be ascertained after tests and more assessment which could not be done until the beginning of the week.]

This information was explained [to the parents]. After two hours of deliberation, they told the attending physician that they refused therapy. They would, they said, place their faith in God. They had recently seen sight restored to the baby's great-grandmother when she was taken to a healing service after a debilitating stroke.

.... They had prayed for a sign from God to help them make this decision, and took the nurse's failure to start an intervenous infusion on the first attempt as just such a sign.

[The physician tried to ask if the parents didn't think that God uses medicine as a part of God's plan but the parents held that was for those who had no faith and they had a 'perfect God.']

.... The child was discharged without therapy with a return appointment at the center's clinic, but the family did not keep the appointment.

⁴⁵Bette-Jane Crigger, ed., Cases in Bioethics: Selections from the Hastings Center Report, 2nd. ed. (New York: St. Martin's Press, 1993), 33. The case as presented here is edited for space and to focus on particular elements relevant to this study.

Commentary

This case provides an opportunity to examine several issues related to autonomy and a covenantal ethic approach. This commentary is arranged not in the areas of consideration outlined by Clinical Ethics, although they will be covered here, but rather in the areas of particular concern to a covenantal ethic. First, however, it is important to note the medical indications in this case. The outcome of medical intervention is uncertain for several reasons. Tests have not been able to be performed that would give a more complete diagnosis. Even with a diagnosis of leukemia, however, the prognosis for a 10-month-old infant "would be statistically less certain . . . than for a four- or five-year old."⁴⁶ The judgment of the parents then at this point of a relatively poor outcome even with treatment in the clinic is not unreasonable.

The next area to examine is the distinction between "meaning" and "the good." In this case both the parents and the medical team represented by the physician want the same thing, to care for and treat the infant. The question on the surface is what is the most efficacious treatment to obtain the goal? But the underlying issue of this question is meaning vs. the good. The physician is trying to work on the good -- the treatment that would bring care and possibly additional years of life. This is the goal of medical intervention.

⁴⁶ Jan van Eys, "Commentary" on the above case in Crigger, 35.

It is the beneficent thing to do. The parents seem to be looking at not only benefit but also the meaning of this whole illness and its place in their lives. Unless this is spoken to, the two parties will be talking about two different things while after the same goal. A covenantal ethic encourages the dialogue on the level of meaning since any event -- physical, emotional or mental -- has a meaning to one's life and the meaning must be responded to and included in the response to the event or action if satisfactory resolution is to be reached.

One of the meanings here is seen in the conflict that has been set up between faith and medicine. It is an interesting reflection that in their history, these two worlds were not in conflict at all but were seen as a part of the same meaning in life. To return, at least in part, to the understanding that faith is a part of medicine and that medicine a part of faith is essential in this case. The covenantal ethic includes the realm of the spiritual and the realm of the temporal and advocates God's presence in both. It is not that God has given the cancer clinic a job to do and then leaves (this, in essence is the meaning of the argument the physician offered to the parents) but that God is in the cancer clinic as a part of God's presence in history. The cancer clinic, it could be said in the view of these parents, needs God and God works in the cancer clinic. The two ways of God giving care to the child do not need to be at odds. To not acknowledge God's real presence in the treatments

given at the cancer clinic ignores the need to respond to the faith meaning that the parents are seeing and need to see in these events.

The second area to address is the area of responsibility. This is an important theme in covenantal ethics. Again, both parties in this case are trying to be responsible but neither is being responsible in a covenantal sense. A responsible faith is a radical monotheistic faith (H.R. Niebuhr). It is not clear in this case if the parent's faith is in an Absolute God or in their absolute faith to do something that will gain something they want from this Absolute God. Henotheism is possible in many ways, and the faith in one's own efforts to do what is right is often hidden is an outward faith in God. Is it responsible to "let go and let God?" A covenantal faith and ethic says, no. God is God and not a god to be manipulated even by the faithful's faith. There must be a way in the resolution of this case to have a theological consultation to sort out the faith objects of the parents, to reaffirm their faith in God but to confirm that their faith is in God and not their attending a faith healing service.

The responsibility of the physician also needs to be examined. The physician's own faith may be an issue in the dialogue with the parents. What is the *effective* treatment for the child is not just a matter of medicine but also of faith in this case. If the physician's own faith does not allow an understanding of the interplay of faith and medicine, then part of the responsibility of the physician for responsible dialogue with these parents is

the physician resolving his/her own conflict with a different view of medicine. That view may not even permit the hearing of the other side from the parents. But if the physician is going to be responsible in his/her authority role, she/he will need to understand their own faith views to be open and honest, let alone helpful, in the dialogue with the parents. The physician will need to address the understanding of the body as a unity of flesh and spirit, not a duality over which the physician has authority and saving the other for faith's authority. The physician will also need to examine the understanding of authority in this case. If the physician understands authority to be absolute in the area of medicine, then there is no room for dialogue with a faith view that understands God as *the* authority in all fields. A responsible covenantal ethic will require of the physician as much faith searching regarding authority as it requires of the parents.

The respect for the autonomy of the infant is another issue. Since the 10-month-old baby can not express autonomous choices in this decision, the respect for the autonomy of the infant gets mixed with the respect for the autonomy of the parents. This is unfortunate. In a covenantal ethic the child does have autonomy in the same way that all do, as a part of community. The parents seek to support the autonomy of the child within the community of the faith healing service. To broaden the community in which the infant's autonomy will be experienced to include the medical community, the above suggested steps in dialogue will need to take place. As

it is presented in this case, there is community present for the parents in the medical community. Respect for autonomy is not achieved in this case by the isolation from the community and the drawing of lines of knowledge and medical authority. It can only be achieved by the inclusion of the family into the dialogue of the medical community in such a way as to make it their community too and not an adversarial one as it stands in this case. The true respect for the autonomy of the infant, as well as the respect for the autonomy of the parents, will be shown by the establishment of a responsible dialogue and process toward resolution suggested by a covenantal ethic.

Conclusion

The above case could benefit from a third party consultation with the parties involved. The purpose of the consult would be to explore the issues, ideas and approaches outlined above. The family's physician could be contacted for additional information about the family and perhaps even be a part of the suggested consult. Someone who could speak to the family's theological and faith questions should also be a part of the consultation. This person, it would be advisable, should be respectful of the parent's faith while trying to open up the areas of exploration outlined here.

The goal of the consultation is to provide a place for the possibility of community in which a covenantal ethical decision can be reached. Unless there is more medical evidence regarding the critical nature of the disease

and the prospect for response to treatment, the parents' decision should, after this consultation, be respected.

CHAPTER 5

Quality of Life and Covenantal Personhood

Introduction

In this chapter quality of life will be examined as presented in Clinical Ethics. One of the bioethical principles involved in using quality of life as input into the clinical decision making process is nonmaleficence. Therefore, this principle will be examined in the second section of this chapter, as primarily presented in the work of Beauchamp and Childress. In the third section of this chapter, quality of life measurements will be examined along with the question of who decides. Then, in the fourth section, a perspective of covenantal ethics on quality of life will be discussed. Finally, a case presentation on euthanasia will be considered and will be addressed using the learnings from the foundational discussions preceding.

Quality of Life in Clinical Ethics

Jonsen and colleagues admit quality of life considerations into the clinical decision making process only with caution and some reservations. The use of such input "rests less on facts than upon preferences about those facts."¹ It is, therefore, a very subjective judgment (whether given by a patient or others regarding the patient) and, although useful, is to be entered into the clinical decision making process only with care.

¹ Jonsen, Siegler and Winslade, 102.

When the second edition of Clinical Ethics was written, attempts at grading or measuring quality of life were only beginning.² For its perspective Clinical Ethics suggests a definition of quality of life with a three-fold evaluation of quality. The suggested definition is in two parts:

- (a) The subjective satisfaction expressed or experienced by an individual in his or her physical, mental, and social situation.
- (b) The subjective evaluation³ by an onlooker of another's subjective experiences of personal life.

Within this definition the authors suggest three evaluations of "quality" in the clinical setting -- poor, minimal and below the threshold considered minimal.⁴ Jonsen and colleagues caution, however, that use of these terms and their meanings when actually making judgments is filled with peril. Evaluations regarding quality can change over time, can be biased by prejudice, may be affected by socioeconomic factors and, if made by an outside observer, are always influenced by that person's outlook, values and even state of mental and physical health at the time.⁵ With all of the cautions and perils, one might ask whether quality of life judgments are useful at all? The authors answer yes, and illustrate its usefulness as a concept and information important to a complete clinical judgment by

² Later in this chapter some of these measurements that were developed in the late 80s and early 90s will be examined.

³ Jonsen, Siegler, and Winslade, 102.

⁴ Jonsen, Siegler, and Winslade, 105.

⁵ Jonsen, Siegler, and Winslade, 103-04.

applying quality of life judgments to several issues, some of which are germane to this study.

Regarding the Termination of Life Support

The primary issue here is whether it is ethically permissible to withdraw or withhold medical intervention because of a quality of life judgment. When quality of life is judged to be below the minimal threshold, the authors state "the ethical justification for refraining from medical intervention seems to us quite strong."⁶ In cases of poor or minimal quality of life judgments, the justification to withhold or withdraw treatment is not so clear cut. The decision must be reached by balancing net benefit over harm to the patient. In two case presentations to illustrate their point, the authors point out that if medical intervention can in fact contribute to medical goals, then quality of life factors alone can not justify withholding or withdrawing treatment. Their conclusion is that only when all other factors are ethically neutral or irrelevant is quality of life to be considered the decisive factor in the clinical decision to withhold or withdraw treatment.⁷

One particular caution offered by the authors carries considerable weight. This is the factor of "bias" in quality of life judgments. Their concern, shared by this study, is that certain classes of people can be

⁶Jonsen, Siegler, and Winslade, 108.

⁷Jonsen, Siegler, and Winslade, 115-16.

categorized as having poor quality of life, such as the mentally retarded or physically challenged. Such bias is seen in an attitude that "quality" is defined by the statistical majority as "normal." Judgments made by those who are not mentally retarded for those who are, are likely to be influenced by a bias of how life is or should be experienced. In the case of Joseph Sarkewicz,⁸ the court tried to guard against standards placed upon Mr. Sarkewicz's life by others by tailoring its decisions to his life experience and not to the presumed experience of life of a class of people who are known as "retarded." This was a landmark case and pointed up the relevance of bias in the determinations of quality of life and how it must be guarded against.

Bias can also be shown by patients themselves. For example, in the case of a patient who has suffered an injury and who judges their future life will be of little or no quality because they are comparing their future life to their past life. Such bias clouds the quality that may, in fact, be able to be experienced. Even though the patient's quality of life would certainly be *different* than before their injury, it may only be their bias which judges it as *worse*. It is for this reason that, even though it is the patient's own judgment, quality of life judgments are always considered with caution in the clinical decision.

⁸Jonsen, Siegler, and Winslade, 111.

Exercising such caution, Clinical Ethics concludes that three conditions must be present if quality of life is to be a decisive consideration:

1. The indications for medical treatment are such that the goal of preservation of organic life without attainment of the other goals of medicine is likely to be the only accomplishment.
2. The preferences of the patient are not and cannot be known.
3. The quality of life of the patient falls below threshold that can, on the basis of wide and objective criteria, be considered minimal.⁹

Regarding Euthanasia

Euthanasia is considered in this discussion of quality of life in that, at times, a patient may judge the quality of their life to be so poor that death would be preferred to life. Euthanasia, or "good death," is thus a term that is used for such situations even though the term is used in many different ways to cover a wide spectrum of medical intervention and non-intervention.

Clinical Ethics treats the subject briefly with most material focusing on the authors' stand against active euthanasia and on a call for better management of pain in medical practice particularly at the end of life. In regard to active euthanasia the authors use tradition (Hippocratic Oath), social consequences, and the possibility of a depressed state of mind of the patient requesting active assistance with death as reasons against the practice. This is not to say that dying persons should be treated aggressively up to the very end of their life. On the contrary, the authors call for better pain management and "an obligation to shift from aggressive therapy to

⁹ Jonsen, Siegler, and Winslade. 115-16.

comfort care when therapy is futile."¹⁰ It is to say that, at the very least, a physician actively assisting in the death of a patient is morally perilous.

The area of pain relief, however, can also be perilous. The principle of double effect comes into play when a physician treats a patient for pain but in the process the medication contributes to the impairment of respiration and eventual death. Is such a result correctly labeled euthanasia, either active or passive? Jonsen and colleagues say no if the intention is not to hasten death but to relieve pain.¹¹ Thus, the principle of double effect can justify an unintended death as a result of intended pain management.

In summary, quality of life, according to Clinical Ethics, is an extremely difficult concept to apply in the decision making process. In order to do so, one must have a better grounding in the moral principles behind its use and in a process by which such judgments can be made. To this task the next section turns.

The Principle of Nonmaleficence

The principle of beneficence and the principle of nonmaleficence are closely related and are usually to be held in a balance particularly in quality of life decisions. They are separate principles, however, and it is important for complete clinical ethical decision making to consider both. Beneficence

¹⁰ Jonsen, Siegler, and Winslade, 119.

¹¹ Jonsen, Siegler, and Winslade, 121.

and nonmaleficence are seen as active principles in that they require an *obligation* and an *action*. Beauchamp and Childress distinguish them in this way: nonmaleficence means "one ought not to inflict evil or harm"¹² and beneficence means one ought to *prevent* evil or harm, *remove* evil or harm, *do* or *promote* good.¹³ Both principles seek to avoid harm. In beneficence by actively preventing or removing it and in maleficence by not inflicting it. Defining harm, however, is not as easy as it might appear at first. In medical practice harm is inflicted intentionally in surgery but this is not considered nonmaleficence. Further distinction is needed.

It is important to distinguish between statements about the justification of harm and statements about the nature of a harm.¹⁴ Some harmful acts are justifiable (in a utilitarian way) because they contribute, in their net effect, to the goals of the individual who suffers the harm. They are therefore inflicted only as a temporary setback to another's interests. The act is still harmful but it is justifiable on balance and, therefore, is not nonmaleficence. Such an understanding of nonmaleficence is applicable to a number of concerns and issues involved in decisions in which quality of life judgments enter.

¹²Beauchamp and Childress, 122.

¹³Beauchamp and Childress, 123 (emphasis mine).

¹⁴Beauchamp and Childress, 124.

The Principle of Double Effect and Nonmaleficence

The principle of double effect is that an action may cause harm but if the harm is not intended then it may be justifiably inflicted. Beauchamp and Childress see problems with this principle and advocate replacing the principle of double effect with the principle of nonmaleficence. They point out that there are two problems with the principle of double effect:

1. conceptual and theoretical issues about the nature of acting (or omitting) intentionally and what counts as an intended effect, and
2. moral problems about whether the principle of double effect correctly locates a morally relevant difference between actions or effects of action.¹⁵

The first problem is in the determination of intention. In the principle of double effect, intentions behind actions must be demonstrated to be planned in such a way that the action would not produce a harmful effect. If it did, the act would be morally justified because it was demonstrated that the intent was not to produce the harmful effect. Such a requirement to demonstration of clear intent is unrealistic in practice.

The second problem is concerned with determining a moral difference between action and effect. The principle of double effect holds that the moral difference between action and effect is in the intended effect. The key question for Beauchamp and Childress, however, is not if a particular effect was intended "as an end or as a means but whether the conditions are

¹⁵ Beauchamp and Childress, 130.

sufficient to justify an intended act."¹⁶ Nonmaleficence is concerned with how harmful a harm is, not with who bears the responsibility for the harm. Therefore, the principle of nonmaleficence does not draw a distinction between intended action and effect but instead examines if a harm was caused by an action and if circumstances justified the action even if harm was intended. To see how this principle works in practice, other distinctions between harm intended and effected need to be examined.

Killing and Letting Die --

Withholding and Withdrawing

Beauchamp and Childress argue for keeping a moral distinction between killing and letting die to protect important societal and professional restrictions on killing but maintain that a distinction between withholding or withdrawing life-prolonging treatment is not relevant morally. These two positions lead these writers to conclude that a general practice of active euthanasia can not be morally justified and that distinguishing morally between withholding and withdrawing treatments only creates a confusing situation that aligns one or the other act with active euthanasia.

With regard to the first conclusion the authors say, "Although particular acts of killing may not violate the obligation of nonmaleficence and may be humane and compassionate, a policy that authorizes killing in medicine -- in

¹⁶ Beauchamp and Childress, 134.

even a few cases -- stands to violate the obligation of nonmaleficence by creating a grave risk of harm in many cases."¹⁷ In this statement the stand of Clinical Ethics is also supported in its concern over bias in such decisions.

In considering the ramifications of allowing the possibility of specific acts of active euthanasia, Beauchamp and Childress consider the question if this can be allowed without allowing all acts of active euthanasia. This is sometimes called the "slippery slope argument" and the authors conclude that some slippery slope arguments in fact support their position of maintaining a distinction between killing and letting die, and keeping this distinction argues against active euthanasia (killing). The authors recognize that there may be an instance in which the prima facie duty to refrain from killing may be outweighed by the prima facie duty to relieve suffering; nevertheless, they still maintain that the keeping of the prohibition is important.¹⁸ There may even be acts of conscience which would go against the prohibition and be justified but that alone would not justify the withdrawing of the prohibition. The theological questions in response to this position will be taken up in the next section, but at this juncture it is helpful to note that underlying Beauchamp and Childress' position seems to be a definition of "death" as a "harm" in all cases. This outlook profoundly

¹⁷ Beauchamp and Childress, 138.

¹⁸ Beauchamp and Childress, 143.

influences the conclusions that they reach, but with a different definition and understanding of life and death a different conclusion may be reached.

While maintaining the distinction between killing and letting die, Beauchamp and Childress do not advocate maintaining a distinction between withholding and withdrawing life-prolonging treatment. If a moral distinction is maintained, then there is an effort to classify withholding or withdrawing as either killing or letting die in specific cases. The authors maintain that to keep a distinction makes a false dichotomy between the two in an effort to justify one course of action over the other. It is "morally indefensible and dangerous," they say.¹⁹

Optional, Obligatory and Wrong

Forms of Treatment

In Principles of Bioethics the language of ordinary and extraordinary treatment is replaced with the terms "optional," "obligatory," and "wrong." These terms, the authors feel, are better terms for drawing moral distinctions. In their view, treatments that are pointless or offer "no prospect of benefit,"²⁰ or where burdens outweigh benefits, are not obligatory treatments and may be wrong.

¹⁹ Beauchamp and Childress, 148.

²⁰ Beauchamp and Childress, 154.

One of the more controversial treatments to try to label with such categories is the administration or omission of hydration and nutrition. These two elements (water and food) are so basic to life that it is often assumed that the administration of them is *always* obligatory, even by artificial means. The authors advocate a position that "no medical treatment as such is always obligatory,"²¹ even hydration and nutrition. The American Dietetic Association agrees with this position even while it advocates the importance of hydration and nutrition from a physical as well as a psychological standpoint.²² What is important about these positions is that they make the value of hydration and nutrition a variable depending on the case rather than a fixed value across cases. Therefore, they are a treatment, and as all medical treatments, they must be evaluated for the balance of harm to benefit. Such balance will determine if the treatment is obligatory, optional or wrong.

Quality of Life Judgments

Deciding if treatments are obligatory or optional will partially center around quality of life judgments. To consider these judgments is the task of the next section. For the purposes of this study, considerable material has

²¹ Beauchamp and Childress, 163.

²² "Position of the American Dietetic Association: Issues in Feeding the Terminally Ill Adult," Journal of the American Dietetic Association 92 (1992): 996-1005.

been added to the basic overview provided by Beauchamp and Childress. However, in their brief overview under the heading of defining obligatory and optional treatment they raise some of the issues that must be addressed:

1. Can quality be measured in any reliable way?
2. Is there a distinction between "quality" and "value" in reference to a person's life in a particular medical situation?
3. How can quality be defined in terms of the life of the individual rather than in the terms of an outside observer?
4. Does quality of life include other factors (such as finances, for example) and other people (family and society)?

To these questions this study now turns.

Quality of Life as a Measurable Factor

In recent years there have been several attempts at designing tools to be used to measure quality of life. Often these have come out of a cost analysis and resource analysis approach. The concern has been to determine when quality is at such a level that it is no longer cost or resource effective to continue treatment. Partially because of their roots in these pragmatic areas being measured, instruments to measure quality of life have come under criticism. All instruments have found it difficult to quantify what is admittedly a heavily value-laden area. Such difficulty in measuring plus other factors have led critics such as Paul Ramsey to "reject all judgments

about quality of life and rely instead on medical indications."²³ Ramsey's views will be discussed in more detail in the next section when the question will be addressed of the applicability of such measures. For now, however, it is important to recognize that even though measurements of quality of life have not achieved general acceptance, the measures exist and the fact that attempts have been made has kept the search for such instruments alive in the area of clinical ethics.

Quality-Adjusted Life-Years

A Quality-adjusted life-year (QALY) is a numerical description of the value that a medical procedure or service can provide to groups of patients with similar medical conditions. Quality-adjusted life-years attempt to combine expected survival with expected quality of life in a single matrix.²⁴

There are several techniques used to determine QALYs and some effort will be made to comment on them here but all of the techniques are founded on six ethical assumptions:

1. quality of life can be accurately measured and used,
2. utilitarianism is acceptable,
3. equity and efficiency are compatible,
4. projections of community preferences can substitute for individual preferences,
5. the old have less "capacity to benefit" than the young, and

²³Beauchamp and Childress, 157.

²⁴John La Puma and Edward F. Lawlor, "Quality-Adjusted Life-Years: Ethical Implications for Physicians and Policymakers," Journal of the American Medical Association 263 (1990): 2917.

6. physicians²⁵ will not use quality-adjusted life-years as clinical maxims.

The detractors of QALYs (LaPuma, Lawlor, Ramsey, Uhlman, Pearlman) advise that the dangers in using QALYs for either health policy decisions or individual patient care are of such magnitude that they are not useful tools. The proponents (Kaplan, Ganiats) argue "the QALY concept maximizes patient benefit" and, in fact, accomplishes the goals of clinical practice that the detractors advocate.²⁶

This study's commentary on QALYs will be divided into two areas: concerns over the instruments themselves, and concerns over the ethical assumptions and effective goals.

In regard to the first area, Eric Nord has provided an extensive evaluation of the methods used for measuring QALYs. Nord noticed considerable variation in the results of the instruments evaluated and argues for an understanding of what is behind these differences if QALYs are to be useful. The observations that are most relevant to this study are:

1. "Most valuation techniques capture more than or something different from quality of life consideration or they do so in different ways."²⁷ For

²⁵La Puma and Lawlor, 2917.

²⁶Robert M. Kaplan and Theodore G. Ganiats, letter to the editor, Journal of the American Medical Association 264 (1990): 2503.

²⁷Eric Nord, "Methods for Quality Adjustment of Life Years," Social Science and Medicine 34 (1992): 561.

example, a particular instrument may ask subjects to choose between continuing in a stage of health or gambling on an alternative that may mean getting well but also may mean dying immediately. Such an instrument may be evaluating a person's tolerance for risks more than their judgment of quality of life.

2. QALYs are generally determined through surveys of people who are not actually experiencing a medical situation that is being evaluated. Therefore, judgments are made by the healthy about conditions they have never experienced. This, it would seem, would certainly affect if not bias the results in favor of a particular state of health as the definition of quality. In a study of a related issue, Uhlmann and Pearlman compared the perception of quality of life between physicians and their patients.²⁸ Their findings were that there were significant differences between the valuations of quality by physicians (who were predominantly younger and healthier than their patients in the study) and their patient. Such differences are used by proponents of QALYs as arguments for the need for such objective instruments. However, it seems that such results would call into question a basic foundation of the surveys: the validity of having the healthy evaluate quality for the sick.

²⁸ Richard F. Uhlmann and Robert A. Pearlman, "Perceived Quality of Life and Preferences for Life-Sustaining Treatment in Older Adults," Archives of Internal Medicine 151 (1991): 495-97.

3. The quantification of quality, in practice, may lead to more confusion than clarification.

Let us assume that two health states A and B are assigned values .04 and .08 respectively. Given the utilitarian interpretation, the following may then be made: 'curing a person in a state A for 10 years leaves society with an increase in well life that is three times as high as curing a person in state B for 10 years.'²⁹

The question is whether society could ever verify such a statement.

The second area of concern is over the ethical assumptions of QALYs.

LaPuma and Lawlor have given the six listed earlier. Incorporating some of theirs, the following concerns are of particular relevance to this study.

1. The standard of quality determined by these instruments is not only biased by the judgment of the healthy defining quality for the sick, but the instruments can not measure quality of life for one who faces a future of altered health. For example, the neonate in intensive care or the mentally or physically challenged person who has been that way from birth can not answer a question of comparative quality to a state of health that they have never experienced. Likewise, the person who has been healthy all of their lives and now suffers from a debilitating accident can not answer a question of the quality of their new life when all they have to compare it to is a standard of their pre-accident days.

²⁹Nord, 564.

2. The utilitarian philosophical base of QALYs belies an assumption behind them that value can be quantified and that an end result (quality) finally means the same finally for everyone. The achievement of this end becomes the goal overriding any concern over process leading to the outcome. Such a stance makes quality, especially as defined by community measures such as QALYs, a trump to patient autonomy and medical indications and may even refine the interpretation of medical indication to fit the sought goal of quality. An assumption in QALYs, especially when used for cost or resource analysis, is that society can afford only so much diversity in its standards of quality. Perhaps this might be described as the slippery slope of QALYs.

3. Finally, any instrument intended to judge quality of life must be separated from any other goal. The close tie of QALYs with cost and benefit analysis has made them suspect to this study and to the process of dialogue giving equal weight to all of the ethical principles involved in a decision. QALYs as they currently are configured, combine quality with justice considerations in such a way as to stack the dialogue in favor of quality as measured by the particular instrument. The final ethical decision then is not so much found through dialogue but out of the underlying goals and definitions found in the QALY.

Who Decides Quality of Life?

In a commentary on an actual case, Tristram Engelhardt writes:

When a patient decides that the future quality of life open to him is not worth the investment of pain and suffering to attain that future quality of life, that is a decision proper to the patient. Such is the case *even* if one had good reasons to believe that once the patient attained that future state he would be content to live; one would ³⁰ have unjustifiably forced an investment of pain that was not agreed to.

The foundational question to which Engelhardt responds is key: How can one treat another person as free while still looking out for that person's best interests? In the context of quality of life, the question might be posed: How can one define for another their quality of life and, if one can not, then is it possible to act in another's best interests? Simply put, the question is: Who decides quality of life? If QALYs, at least as they are currently conceived, can not give us objective measures, then decisions about quality of life are left to the people involved. Most perhaps would argue (as does Engelhardt above) that the person him or herself should decide either ahead of time by advanced directive or, if competent, at the time of the need. But, if patient preferences are not known or if they conflict with those of the patient's family or perhaps even the patient's physician, then who decides? John Arras argues that in cases of an impaired infant at birth even the parents should not have unbounded authority to make the determination of

³⁰H. Tristram Engelhardt, Jr., "Commentary," in Cases in Bioethics, 2nd ed., ed. Bette-Jane Crigger, 121.

quality of life.³¹ He argues that only by a return to decisions firmly based on ethical principles can treatment decisions be made. Patients' judgments may be too clouded by other factors. Hadley Arkes, speaking from a legal perspective argues similarly: "We can not separate claims for quality of life . . . of patients outside the discipline of moral reasoning. The attributes of 'cognitive' and 'sapiant' states, the tests of 'consciousness' and 'relatedness,' and the anticipations of embarrassment, distress, and psychological strain are all attributes without any necessary moral significance."³²

In a complete change of approach, Braitwaite and Thomasma have argued for a disguarding of the whole idea of measuring of quality of life in favor of an Anti-Cruelty Policy. Their particular concern is the decision over foregoing life-sustaining treatment for the incompetent patient. They argue that rather than judging quality of life, a decision should be made on the basis of an anti-cruelty policy which basically amounts to a practice of the principle of nonmaleficence.

By "cruelty" we mean aimlessly inflicting or perpetrating pain, injury, grief, or suffering, or interrupting a timely death or a kindness of nature. By "aimless" we mean undertaken without rational intent of potential benefit. A "timely death" occurs

³¹ John D. Arras, "Toward an Ethic of Ambiguity," Hastings Center Report, April 1984, 25-33.

³² Hadley Arkes, "Autonomy and the Quality of Life: The Dismantling of Moral Terms," Issues in Law and Medicine, May 1987, 432.

when a person with a hopeless injury . . . dies as an act of nature.³³

The authors argue that quality of life is too subjective a judgment that can not be satisfactorily quantified and is open to much abuse. Therefore, only a practice of nonmaleficence is justified and workable.

Ambiguities Are Important

The common goal of the above critical comments and of the search for a QALY that will quantify the decision regarding quality of life is to take the ambiguity out of the judgment. But that may be the wrong goal. Indeed, as this study argues, the ambiguity is an important (if not essential) quality in the quality of life and once that is affirmed, then it can be put to creative use in determining quality of life. To this goal the next section is addressed.

Quality of Life and Covenantal Ethics

Sanctity of Life and Quality of Life

The sanctity of life is a phrase that has been used to convey many meanings. As theology intersects with bioethics, it generally brings to the dialogue the idea that life is a gift from God and that human beings are its stewards. Sometimes sanctity and quality of life have been viewed as conflicting when quality judgments are viewed as placing a value by degrees on life. Sanctity proponents say that life is valuable not by degrees but by its

³³Susan Braithwaite and David C. Thomasma, "New Guidelines on Foregoing Life-Sustaining Treatment in Incompetent Patients: An Anti-Cruelty Policy," Annals of Internal Medicine 104 (1986): 712.

existence and that life in all its conditions holds an equal value because it is created and given by God. Paul Ramsey argued this line of thought. All lives are of "equal and independent value," he said.³⁴ And again, "our God is no respecter of persons of good quality."³⁵

This position is sometimes seen as being in conflict with autonomy in bioethics where it is advocated that one is free to determine the value of one's life in terms of its quality rather than its value in God's creation. Gerald Coleman, however, argues that a stress on autonomy in quality of life judgments has resulted in a claim "that when one's own life lacks sufficient quality or diminishes the quality of others', suicide is the best ethical solution."³⁶ Coleman's sanctity of life position and his concerns over assisted suicide are grounded in the Roman Catholic tradition and several of its pronouncements regarding human life and medicine.³⁷ But others raise serious reservations about a sanctity of life approach: "If human life has

³⁴Paul Ramsey, Ethics at the Edges of Life: Medical and Legal Intersections (New Haven: Yale University Press, 1978), 261.

³⁵Ramsey, 203.

³⁶Gerald D. Coleman, "Assisted Suicide: An Ethical Perspective," Issues in Law and Medicine 3 (Winter 1987): 269.

³⁷In his article, Coleman uses as his sources the National Conference of Catholic Bishops, "Guidelines for Legislation on Life-Sustaining Treatment" (1984); and Pope John Paul II, "On the Meaning of Human Suffering, L'Osservatore Romano," 20 February 1984.

absolute value or infinite value, it trumps every other socially acknowledged value."³⁸

The approach of covenantal ethics, while maintaining agreement with the idea that life is sacred, still finds "quality" to be a useful term in referring not to life's overall value but to its circumstantial value. Quality of life judgments, then, must be separated from a judgment regarding the *value* of one's life. It is rather a situational judgment of the experience of one's life at the current moment. Thus, quality does add an important *measure* to life's experience but it is only a measure of the moment. To be useful in ethical decision making, this judgment of life's current experience must be put within the context of the value of one's total life experience. Key to this approach is a creation theology that affirms life as process and life's value not as static but as found in the process and in God's presence in the continuing processes of one's life and creation. A covenantal understanding of history affirms that the meaning of our lives and therefore its quality are found in God's presence and activity, not only in one's own time in history but in the total time of God's history. This then "protects" one from using quality of life at the moment as a quick judgment, but rather it places quality within the context of God's history and continuing presence in life; in other

³⁸ Amnon Goldworth and David K. Stevenson, "The Real Challenge of 'Baby Doe': Considering the Sanctity and Quality of Life," Clinical Pediatrics 28 (1989): 121.

words, within the *meaning* of one's life, not just its existential experience. Suffering (see Chapter 2) among other experiences, has a different *meaning* and determines quality in a different way than an immediate negative judgment. Death, too, is seen as a part of the process of life, not a negation of it. Covenantal theology "grounds an ethic that honors life yet receives death in due season, not when it is our whim but when we can discern the divine call in our soul and in the corroborative adieu of the loving community."³⁹

The "Value" of Death

Death, in medicine has often been conceived as defeat. Society too has held death as having a negative value. The origin of such an idea lies in its conception of human life as a duality. In such a concept, death marks the *end* of life because the body dies. The theological answer to this was to accept this dualism but to say a new life begins at death with the freeing of the soul. Physical death is still seen as the end of life but it is transformed, at least, partially into a positive rather than a complete negative reality.⁴⁰

A covenantal ethic approach would argue that death is *prima facie* neither negative nor positive, rather, its value can only be seen as it is viewed as an integral part of the total process of life. In this conception, choices and judgments regarding quality at the end of life are made not as a

³⁹Kenneth L. Vaux, Death Ethics: Religious and Cultural Values in Prolonging and Ending Life, (Philadelphia: Trinity Press Intl., 1992), 23.

⁴⁰Moltmann, 248-50.

choice between life and death but as a matter of *when* in the process of life death comes and the *meaning* of the time in which it comes. The *when* does not automatically imply a support for active euthanasia. It refers to the occasions when one is able or must make decisions about the termination or the withholding of life-sustaining measures. By contrast, if one argues a traditional view of death as good or bad, one misses the whole *meaning* of the experience and attaches a human value to life that only God can really give.

The key then is an emphasis in ethical decision making on *meaning*, one factor of which is its quality. Sanctity implies life is good yet finds itself in the dualistic trap at death of shifting the good from life to death. In such a framework, it is not surprising that quality has no place. For quality as a good to be attained or judged against is an illusive definition that changes with where one is on the continuum of life to death. If existential quality of life is understood only in the context of life's overall meaning, as in a covenantal approach, then terms such as good and bad quality only serve to describe the experience of the moment but do not help to evaluate the ultimate value and the meaning of the experience.

Personhood

The dualistic approach to human life also brought with it a mechanistic approach to physical life. Descarte found wonder in a conception of the body

as analogous to a finely crafted watch.⁴¹ The person in such a conception is the "I" that exists over and above the mechanism. "The 'I' stands over against body, which it commands and utilizes as its property."⁴² In this approach the person is defined by one's capacity to think, reason, and control one's body. When one is no longer able to do this, one has lost the quality in one's life, indeed may have lost *life* itself.

Such mechanical understanding of the body continues in much of scientific inquiry today. In the area of genetic research the *person* has been reduced to the potentiality in the genetic code. Research endeavors to break the code and in so doing, it is believed, will be able to determine how to create a certain outcome. The *person* -- the physical, mechanical body that results -- will be the triumph of the mechanical manipulation of the pieces of the genetic code.⁴³ Covenantal ethics argues against such a conception while acknowledging that the genetic research into the beginnings of physical life helps to refine the understanding of what defines personhood.

⁴¹Moltmann in God in Creation, 251, quotes Descarte's "Meditations" for this concept.

⁴²Moltmann, 251.

⁴³David Holbrook is concerned: "It is important to provide protection for the natural processes by which a human being comes into the world, against the Faustian ambitions of some of mechanistic science and of technology which has outstripped ethics and is reckless with its own ignorance." See Holbrook, "Medical Ethics and the Potentialities of the Living Being," British Medical Journal 291 (1985): 462.

In answering the question of when does *life* (and perhaps *personhood*) begin, Daniel Callahan has described three schools of thought: the genetic school, the developmental school and the social consequences school.⁴⁴

Nelson and Rohricht advocate:

The developmental position is most adequate for pointing to the beginning of human life. Like the genetic school, it takes biologic data seriously. Like the social consequences school, it realizes that part of the question is in fact a moral policy question. However, unlike the genetic school (which argues that all forms of human life must be valued equally), the developmental position insists on weighing the comparative values of different qualities and stages of human life that may be in competition in a given situation. Yet unlike the social consequences position, the developmentalist will not make the meaning of being human simply a matter of social utility or what is most useful to the persons who are making the decisions.⁴⁵

Ironically perhaps, the value to the developmental position is in its ambiguity. It highlights that the human person is not a matter of the body or a whim of a judgment made about the usefulness or condition of life. Rather, the ambiguity recognizes a more fluid than fixed understanding of *personhood*. One that allows for the interplay of values over the course of physical life. It stresses a value to life but does not define personhood exclusively by it. Such a conception admits a judgment of quality as it balances the physical existence with the personal experience of existence.

⁴⁴Daniel Callahan as quoted in James B. Nelson and JoAnne Smith Rohricht, Human Medicine: Ethical Perspectives on Today's Medical Issues (Minneapolis: Augsburg, 1984), 19.

⁴⁵Nelson and Rohricht, 20.

Again, the ambiguity allows for an active God in history to be a part of the determination rather than one who defines a *person* and then leaves the scene of creation.

Quality -- A Community Concept

Part of a developmental approach affirms that one's personhood includes identity as part of community. This is a key concept to covenantal ethics. When cut off from community we are cut off from true personhood and, therefore, from God. Quality, then, is a concept of community.

Biblical tradition has recognized this important part of life from Adam ("It is not good that the man should be alone," Gen. 2:18, NRSV) to the new Christian community of the church seen in an interdependent community ("For just as the body is one and has many members, and all the members of the body, though many, are one body. . . ." 1 Cor. 12:12, NRSV). In such an understanding, quality is not measured individually but communally. The implications of this for a covenantal ethics approach to clinical ethics can be seen in two areas.

First, when one is physiologically unable to respond to one's community it is a significant factor in drawing the line at the threshold for quality of life. It is important to clarify that it is not *the* factor of determination. But certainly, to be cut off from community in terms of one's sensual experience of it is to reduce one's own experience of life to below a threshold of quality.

Second, if quality is an experience of community then its definition should come from one's interpersonal community and one's intrapersonal community. In medical decisions when physical life is compromised in some way by illness the meaning of quality of life can best be determined as one's internal values and the values of one's community enter into a relational dialogue. H. Richard Niebuhr describes such an approach as a value relational one⁴⁶ in which in the dialogue within oneself, with one's internal community, and with one's external communities one forms a value center from which to make ethical decisions. Quality of life decisions are made in just such a way.

In addition to the importance of this approach for determining one's own quality of life, it is also an important concept for determining the quality of life for one who is not able to express his/her own value preferences. In such a situation the covenant community exists to protect particularly the ill from having a healthy quality of life standard thrust upon them. Knowing how important an internal understanding of quality of life is to the determination of quality for oneself, as a part of a covenantal ethic one moves to protect and affirm, as best one can, the internal value system of those unable to speak for themselves as quality determinations are made.

⁴⁶Niebuhr, "The Center of Value," supplemental essay in Radical Monotheism and Western Culture, 100.

To summarize, one's own appraisal of quality comes in a value-relational dialogue within and without. This appraisal is time relative, finding that meaning and, therefore, quality change over time even though the value of life is always sacred. Quality is also a community concept and is thus not a strictly autonomous one. An implication of this is that the community's assessment of quality, when made for someone unable to make it for themselves, always is sensitive to the quality of life appraisal from the perspective of the one who is unable to participate in the judgment and not exclusively from the viewpoint of the outside "healthy" community.

A Response to Ramsey

Before leaving this section, a specific response to Paul Ramsey's critique of quality of life determinations must be made for it was Ramsey who pioneered the work in a covenantal ethic in medicine.

One of Ramsey's concerns was that quality judgments deny the equality of the value of human life in God's sight.⁴⁷ It is the response of this study that Ramsey has confused "quality" with merit or net worth. A distinction has been made here regarding human life's value and the conditions of life at any particular time which affect a judgment regarding its quality. Ramsey's critique, however, does provide a helpful safeguard to pure relativism or to a henotheistic worship of one's quality condition in life over another's.

⁴⁷Ramsey, 261.

A concern of this study is about Ramsey's confidence in medical indications to determine clinical decisions, thus intentionally avoiding quality of life determinations from entering into an ethical decision. As argued in Chapter 3, medical indication judgments are never made value free. Indeed, behind a particular treatment decision is a judgment that changing a particular condition in life will be better than not changing or treating. Such a determination, whether explicit or not, is at least partially based on a determination of quality and a goal to move the patient from one quality of life experience to another. Rather than placing one's faith in medical indications judgments that only veil the quality of life determinations, this study advocates an open dialogue with the quality of life assessments of the community, internal and external, involved in the decision. The ambiguity inherent in such a dialogue is an affirmation of faith over scientific method and introduces an essential factor into the complete ethical decision.

A Case Presentation -- Euthanasia

The Case

The following case may or may not be an actual case. When it was published in January 1988 in the Journal of the American Medical Association it caused quite a lot of dialogue on the subject of euthanasia.⁴⁸

⁴⁸The description of this case as presented here is based on the telling of it in Beauchamp and Childress, Principles of Bioethics, 143.

Because of its simplistic presentation (without many details), it provides an opportunity to fill in the blanks with different scenarios that will help round out some of the issues present in other similar but more detailed cases.

Debbie was a 20-year-old woman who was dying of ovarian cancer. On the night in question she was experiencing unrelenting vomiting, weighed only eighty pounds, had an intervenous line, was receiving nasal oxygen and was sitting in bed suffering from severe air hunger. A gynecologist resident was called by a duty nurse reporting that Debbie was having difficulty getting rest. The resident did not know the patient nor the case previous to the phone call.

Upon checking the patient's chart before going into the room, the resident discovered the above information plus background that Debbie had not eaten in two days, was receiving only supportive care and had not responded to chemotherapy. Once in the room, Debbie's only words to the resident were "Let's get this over with." There was an older woman in the room, but she made no comment and was not identified as to her relationship to Debbie. The resident had the nurse draw twenty milligrams of morphine sulfate and the resident injected it intravenously into the patient after telling the woman that it "would let her rest" and "to say goodbye." Another version of the telling of the case presentation ended with this story:

The older woman stroked the hair of the now sleeping patient. I waited for the inevitable next effect of depressing the respiratory

drive . . . the breathing slowed . . . became irregular, then ceased.
 "It's over, Debbie."⁴⁹

Commentary

Euthanasia, as discussed in the model of Clinical Ethics, can be classified as active or passive. The passive variety is widely accepted with some carefully thought out qualifications regarding the terminal stages of a disease and that the measures that lead to the end of the person's life are not aimed at killing the patient but "allowing nature to take its course." It is the active variety that is represented in this case (assuming that the resident knew that the dose of morphine was of such strength as to stop respiration and cause death) that is of immediate concern and more productive for the purposes of furthering this inquiry.

In Clinical Ethics and Principles of Biomedical Ethics the recommendation is against any legalizing or societal condoning of active euthanasia, particularly when a physician is actively assisting in the death. The reasons for this recommendation will be considered here and, although the position of this study in covenantal ethics agrees that a legalization of active euthanasia would cause more problems than it would solve, there is still room for "the exceptional case."

⁴⁹Kenneth L. Vaux, "The Theologic Ethics of Euthanasia," Hastings Center Report, January/ February 1989, 19.

The legal rule against killing can be maintained even if physicians and others sometimes find that it is morally permissible to engage in justified conscientious or civil disobedience against those rules. . . . [In the exceptional case,] the important point is that if pain and suffering of a certain magnitude can in principle justify active killing, then only acts of conscientious refusal to follow the rule of practice will be justified (as long as certain other conditions are met), not fundamental changes in the rule itself.⁵⁰

The case of Debbie, however, does not, as it stands, represent a good example of the exceptional case.

To appreciate the exceptional case one must first admit that medical technology has created them. Due to the benefits of this technology, formerly fatal diseases have been conquered or controlled in such a way that now new diseases that result from longer life, such as Alzheimer's, are causing the conditions of the exceptional case. In Debbie's case, her chemotherapy had altered her physiology and biochemistry. It may have bought her some time but also modified her pain threshold and her ability to eat without artificial feeding. Thus, part of the stage setting for active euthanasia involving the use of technology to end one's life is to recognize that technology, in addition to benefiting the patient, has also already inflicted harm and thus has already violated, at least on balance, the principle of nonmaleficence.

Does this give the patient a right to ask for assistance in carrying out a suicide? First, it must be said in response, it is not clear at all in this case

⁵⁰ Beauchamp and Childress, 146. See also Vaux, "Theologic Ethics of Euthanasia," 20-21; and Robert Veatch, Death, Dying, and the Biological Revolution (New Haven: Yale University Press, 1976), 97.

that Debbie was requesting active euthanasia with her statement "Let's get this over with." (More will be said about the resident's interpretation of this remark in a moment.) But, for the purposes of answering the question, a case can be envisioned where the patient does clearly ask for such assistance. Is this a patient right to do so given that the reason that the request comes is partially from wanting to draw the line on the harms inflicted by technology? From a legal standpoint the courts have chosen to make a distinction between a patient's right to die through natural death and a patient's right to have assistance in causing death. The courts have ruled the first legal, the second illegal.⁵¹ The law would then seem to disallow the exceptional case in which a patient asks for assistance with their death. The court has not said the patient does not have a right to do so (perhaps thinking this is more of a moral question than a legal one), only saying there is not a right for someone to respond to such a request with active assistance to die. Again, as Jonsen and colleagues argue, this may be a prudent course for law to take. However, it does not define the course for a covenantal ethic. There are several other factors to consider, but within the context of a loving covenantal relationship it does not seem unreasonable for persons to ask help from those they love and trust for assistance in dying. What are some of the other factors?

⁵¹Yale Kamisar, "Are Laws Against Assisted Suicide Unconstitutional?" Hastings Center Report, May/June 1993, 33.

In the case of Debbie, the resident from the information available did not assess at all the patient's request and had no long term personal knowledge of the background for the request. Assessment of the patient's wishes is one of the factors and is an essential component in considering active euthanasia. "As we increase our ability to sustain life in a wrecked body we must find ways to assess the wishes of the person in that body We can no longer blindly hold to our instinctive tendency to regard death as an adversary. . . . Nor must we accept immediately and at face value a patient's demand to be allowed to die."⁵²

The demand to die or ask for assistance in death could be due to any number of factors. It could be the one way a patient can actually assert some control when all the rest of their physical life is being controlled by technology. It could be they are deeply depressed or they are responding to family or societal pressures. It is crucial that the patient's wishes be accurately assessed.

From a covenantal ethic standpoint, it can be assumed that a request to be assisted with death could be a breakdown of faith, hope or community, and certainly of meaning. A caregiver is first bound to "attempt to help that

⁵²See Robert B. White's commentary on a case presentation in Crigger, Cases in Bioethics, 120.

person discover or recover faith, hope and love.⁵³ The essential goal is to enter into such a covenantal discussion of values, place them within the context of the current physical and psychological realities, and be as certain as possible that the patient's request is sincere and that they have taken into their decision all the information and factors applicable and available. This, of course, assumes a "neat case" where the patient is completely competent and able to reason clearly and unencumbered from the effects of drug therapy. In most cases this is not the situation and so the role of the covenantal community is especially important. For only a community that is bound to the patient in covenantal responsibility, as H. Richard Neibuhr would call it, can have any legitimate claim to speak on behalf of the incompetent patient.

Even after the decision has been made to actually assist the patient with death a troubling question remains: Who should assist? Two arguments against physician participation are that (1) it undermines the trust placed in that role,⁵⁴ and (2) that the physician motivations are crucial⁵⁵ and since

⁵³Ernle Young, "Assisting Suicide: An Ethical Perspective," Issues in Law and Medicine 3 (1987): 287.

⁵⁴See Nancy Dickey's commentary on a case in Crigger, Cases in Bioethics, 145.

⁵⁵Young, 289.

motivation cannot be assessed before the fact, it would at least be impossible for physician assistance to be condoned legally.

In contrast to the first comment regarding trust, a covenantal ethic would highlight this as being a reason to support physician assistance with death. The case of Debbie shows what this trust does not mean. Trust is established over time and as a part of community. If a physician has built up this relationship and has no other conflicting motivations, the trust placed in the physician in making the request may support physician participation. Second, although one's pure motivation may not be able to be determined and it may not be the time to legalize physician assisted active euthanasia (to safeguard against abuse), life decisions in moral areas are never without some degree of uncertainty. It is a foundation of covenantal theology to recognize one's fallibility and sinful nature and to affirm that it is by the grace of God that humanity has been given the responsibility of moral decision making, the possibility of failure, the forgiveness for sin and the assurance that neither our will nor our mistakes determine the final value or outcome of our life. It is only with such faith that any moral decision and certainly one of such magnitude as active euthanasia, could be entered into.

Finally, since treatment considering quality of life determinations is founded on a balance of the principle of nonmaleficence with beneficence, a question must be asked if a specific case of active euthanasia is an act of maleficence. The key to this determination is in the judgment of what

constitutes "harm." Is it harmful to continue ineffective treatment or harmful to cause death? If death, as has been argued here, is not a prima facie harm, then there is room for an interpretation of harm based on all the factors involved. In Debbie's case, as it was reported, one must conclude it was an act of maleficence for there was no covenantal relationship among the resident, Debbie and the family. Nor was there any assessment of Debbie's wishes. For these reasons alone, this case is one of maleficence. However, under different circumstances, active euthanasia could be considered beneficent.

Who decides finally if it is a beneficent act? This question has been discussed in general earlier. In this particular case a covenantal ethical community should be considered, including Debbie, her regular physician, her family members, clergy, and, finally, an ethics committee trained in the issues and process of bioethics. Such a collaborative community should be able to determine the patient's wishes and evaluate the most beneficent action.

Conclusion

Perhaps, if such a process could be standardized, even with court review, then and only then could active euthanasia be legalized. It may be impractical for such a process to ever exist for every case and, therefore, at this point in our history this study would argue against legalizing of active euthanasia but would also hope that one day soon a covenantal ethic

approach could contribute to the bioethical dialogue in such a way as to at least legally allow for the exceptional case.

CHAPTER 6

Contextual Factors and Covenantal Justice

Introduction

This chapter examines contextual factors in the clinical ethics decision making process. The diversity of these factors as presented in Clinical Ethics illustrates the complexity of this area of consideration. Justice, as the ethical principle most relevant to this area, will be discussed using primarily the work of Beauchamp and Childress. In the next section the approach to justice from a covenantal theology and ethic will be studied and issues raised that will refine the concept to be used in this area of ethical decision making and particularly as it is applied to the case study. The case study in this chapter will deal with the issue of rationing of health care resources from a covenantal ethic perspective.

Contextual Factors in Clinical Ethics

In the second edition of Clinical Ethics this area is called "Socioeconomic Factors." At the 4th Annual Summer Seminar in Health Care Ethics, Jonsen introduced the new title of "Contextual Factors" saying that the new title encompassed more of the elements considered within this particular area. This area includes many "other factors" that are considered in the clinical ethics decision. In some ways it is the catchall for the decision making process to ensure that all of the relevant information that is not covered in the other three areas is covered in the total case presentation. It is also the

place where the several levels of relationships involved in the case are examined. For example, it is where the family circumstances, if relevant, are considered, where financial concerns are examined and where the interests of third parties (insurance companies, hospitals or clinics, and society's resources and values) are taken up. It is, therefore, a complex area and one that has so many other considerations from outside of the immediate physician/patient relationship that it has been a most difficult and often ignored area of clinical decision making. In today's medical practice, with the pressures to provide some level of health care for all of society's members within the ability of society to pay for such care, this area is becoming more and more center stage for the contemporary ethical decision.

Factors for Consideration

The factors that are considered in this area include the role of interested parties other than the patient, costs of medical care, and allocation of resources. "The question raised by these factors is whether, and to what extent, burdens and benefits accruing to persons other than the patient should be relevant or decisive in clinical decisions regarding the patient."¹ The answer of Clinical Ethics to this question is to consider and give decisive weight to these factors only when the factors in the other areas take on less weight in a particular case. Thus the preference is clear in Clinical Ethics

¹ Jonsen, Siegler and Winslade, 130.

that most weight should be placed on the duty to the patient's welfare and preferences. When contextual factors do have sufficient weight to be considered in a particular case the principle of justice may help to address and give direction to a decision.

Clinical Judgment and Health Policy

When clinical judgment and health care policy such as cost containment issues are in conflict, the position of the physician is most precarious. The physician in such a situation is not only a clinician but also a gatekeeper for their clinic or hospital or even for all of society. It is important for the physician to keep her/his role separate and clear in such a situation. There is a need, advocated by Jecker and others, for a system in which the physician can make clinical decisions rather than trying to set policy in clinical decisions case by case.² One reason for this is to keep one's accountability straight. "The physician is accountable to the individual patient and *not to the public*."³ In reality, though, clinical decisions are often influenced by social and institutional policies that favor one group over another and, therefore, the dilemma for the physician is unavoidable. Clinical Ethics endeavors to come to the aid of the physician caught in the dilemma by

²Nancy Jecker, "The Health Professional's Ethical Role in Allocating Scarce Medical Resources," paper delivered at the 4th Annual Summer Seminar in Health Care Ethics, University of Washington Medical School, 9 August 1991.

³Jonsen, Siegler, and Winslade, 131 (emphasis mine).

examining several areas where the conflicts occur and gives counsel through case consideration. For the purposes of this study only those relevant scenarios will be examined here.

Role of Interested Persons

Interested persons here refers to those within the patient's immediate circle of family and perhaps friends who may be in a legal care-giving role. The advice of Jonsen and colleagues is that family wishes are important insofar as they may be a good source of information regarding the patient's own wishes if the patient is unable to speak from her/himself. However, the family is not in a legal position of rights unless there has been such a designation by the court. The patient maintains their autonomy unless the court has granted guardianship to the family or unless the patient has given a legal power of attorney for health care to a family member. The exception to this rule is generally in the case of parents of minor children in which case the courts recognize the authority of the parents to express the preferences for the patient. Thus, the counsel of Clinical Ethics is for the physician to take the family's expression of wishes into consideration insofar as they give insight into the preferences of the patient but not give them final power to determine the course of treatment.

Determinations of the patient's best interests for practical clinical decision making should then consider the attainment of medical goals and

the evidence of the *patient's* definition of "best interest." With these two pieces of information these recommendations are made to the physician:

1. Work to attain the medical goals,
2. If only maintaining organic life then this is not in the patient's best interests.
3. If there is no evidence of the patient's definition of "best interest" and there are no medical goals to be attained, then assume that further treatment is not in the patient's best interest.
4. If the patient's best interests are known, then they should be followed unless heavy costs and burdens are imposed on others.⁴

The last recommendation brings into the discussion the burdens of medical treatment on others. Most typically the first consideration is for the family on whom the burden of cost will fall. The relief of their burden should be considered, advises Clinical Ethics, but it should usually not be decisive.

Cost of Care

The interests of others may come into the decision making equation at the place where costs of health care get to be a burden. It is at this juncture that usually the interests of others outside of the family also enter into the decision since most health care is supported by third parties, either insurance companies or, in the case of the uninsured, by health care institutions or society at large. The old attitude was that everything that can be done and that might benefit the patient and that the patient requests or does not refuse should be done.⁵ This attitude is no longer possible to use as

⁴Jonsen, Siegler, and Winslade, 139.

⁵Jonsen, Siegler, and Winslade, 144.

an operating strategy and so physicians often find themselves in a position of making clinical decisions based on cost. But not just the cost to the patient but to other parties as well. Some would argue the physician only has a relationship with the patient as far as cost containment is concerned while others would argue (including this study) that the physician has a social and collective responsibility and therefore does have a role in allocating resources considering the interests of others. The question is the relative weight that these other interests should play in a decision and how that decision is to be made. The author's of Clinical Ethics recommend the following in the use of cost considerations in reaching clinical decisions:

1. Medical indications and patient preferences should retain priority.
2. Preserve important elements of the doctor-patient relationship.
3. Maximize patient and physician autonomy within limits imposed by health systems.
4. Provide a local appeals process for patients and also physicians.⁶

Allocation of Scarce Resources

Cost can be a factor in the allocation of limited health care resources but so can the limitations of time, equipment, and personnel. These also enter the decision making process under "Contextual Factors."

The allocation of these resources, sometimes called rationing, has been done perhaps since the beginning of medical practice. Rationing (sometimes called "soft" rationing) occurs as physicians make decisions regarding the

⁶Jonsen, Siegler, and Winslade, 150-52.

best use of their time in treating some patients over others and the best use of the resources of their clinic or hospital in treating a particular case. Such soft rationing decisions are made based on the physician's own best judgment, perhaps being guided by institutional or collegially developed policies. These decisions are made on a *microallocation* level and have been accepted as a legitimate part of medical practice.

There are some decisions made on the microallocation level which have been more closely scrutinized, especially recently. Examples include decisions regarding who should be admitted to a treatment program and how that decision is made. The criteria used to allocate this recourse can be on the basis of ability to pay, the efficacy of the treatment for a particular patient judged on the amount of healthy years or time that a treatment would bring to the patient, the social worth of the patient judged by their contribution to society after or before the treatment, and/or the use of the patient's case for study that would benefit future patient's with similar case dynamics. Another example of rationing on the microallocation level is two patients needing to use the same piece of medical technology but having only one piece of equipment to use. When such situations exist, the physician must make a decision based on what is most just, and this is determined by a complex set of individual and society standards. Often the problem for the

physician is "how can I be a *just* physician or, more seriously, is it even possible to be a just physician in an unjust system?"⁷

There are also "hard rationing" decisions in clinical ethics. These decisions are policies that are set and approved, usually by institutions, that guide the use of resources. Policies can include how many non-paying patients a particular institution can accept and still maintain a service to the rest of their public. Physicians are bound by these decisions if they are a part of the institution and the hope is that they have had a part in the establishment of those decisions.

On a broader scale there are also *macroallocation* decisions in rationing. These are hard rationing policies that are set by a larger group such as a local community or a national society and will determine how health care resources will be used. The physician is, as a licensed practitioner, bound by these policies also. There will be times when the policies conflict with the physician's clinical or ethical judgment. At such times Clinical Ethics is silent in its recommendations but this study will broach the subject under covenantal responsibility.

As in each of the other areas presented by Clinical Ethics, there are conflicts to be resolved in dealing with the contextual factors of a particular case. The resolution of these conflicts will depend, in part, on how one

⁷ Jonsen, New Medicine and the Old Ethics, 43.

defines and applies the principle of justice. The examination of this concept is the next task, then, for this study.

The Principle of Justice

To study the concept of justice the writing of Beauchamp and Childress will again be central. As in the use of each of the other principles in bioethics, justice for Beauchamp and Childress must compete with the other principles in arriving at a decision. No one principle trumps the others in all situations but is balanced and weighed against the others within the specifics of a particular case to arrive at a final decision which will place greater weight on one principle over another and thus guide the outcome of the decision.

What is unique about justice as a principle is that by definition it quickly raises questions about one's relationship to and with others, particularly in the area of distributive justice, which is the focus of the case study in this chapter.

Within the concept of justice there are several principles and several theories. One principle, attributed to Aristotle, is common to all theories: "Equals must be treated equally, and unequals must be treated unequally."⁸ Certainly there are several difficulties with this formal principle of justice as it is sometimes called. Among them is the standard used to define equal and

⁸Beauchamp and Childress, 259.

how far this equality extends. Efforts to define equality have resulted in definitions of relevant characteristics used to determine a just method for equal distribution of resources. Beauchamp and Childress list an example of six such characteristics recognizing that any one method may rely on one or more of the characteristics and that there will be conflicts between them.

The six listed are:

1. To each person an equal share.
2. To each person according to need.
3. To each person according to effort.
4. To each person according to contribution.
5. To each person according to merit.
6. To each person according to free-market exchanges.⁹

There is, however, still a need for further clarification in the defining of terms used in these characteristics. What, for example, defines need? What are the relevant properties of such need defined clearly and uniformly so that the principle of justice can be applied? These questions will need to be addressed in any theory of justice and the principles from that theory that guide distribution of resources.

There are three types of justice theories identified in Beauchamp and Childress -- utilitarian, egalitarian, and libertarian. Utilitarian theories do not recognize a separate principle of justice but rather see it as an obligation of utility, i.e., to accomplish the greatest good for the greatest number there

⁹Beauchamp and Childress, 261.

will, of necessity, be tradeoffs and such tradeoffs will define what is just in order to reach a desired end.

Libertarian theories are concerned more with process than public utility as far as distribution is concerned and any scheme of distribution is just if it is freely chosen. In the libertarian view of distribution, resources could be distributed on a free-market basis and although resources would not necessarily be distributed equally, it would be just if those within the system chose to distribute the resources that way.

Egalitarian theories are opposed to the strict procedural justice stance of the libertarian. "Egalitarian theories of justice propose that persons should be given an equal distribution of at least some goods and services, such as health care."¹⁰ In practice, egalitarian theories do not have to call for absolute equality in distribution but recognize a certain level of equality that applies to all. Such theories might call for a minimum level of health care to which all are equally entitled. The distribution of resources, then, would be made according to need and such needs would be satisfied because all would have access to the services that filled that minimal need defined.

The egalitarian approach also incorporates another element absent in consideration by the other two -- the rule of fair opportunity. This rule

says that no persons should be granted social benefits on the basis of underserved advantaging properties (because no persons are

¹⁰ Beauchamp and Childress, 268.

responsible for having these properties) and that no person should be denied social benefits on the basis of underserved disadvantaging properties (because they also are not responsible for these properties).

The application of this rule enables for larger and unequal distribution of resources to certain persons in a population (such as the disadvantaged, mentally retarded, or physically challenged) because it evens out the circumstances of life, to a certain extent, that have caused the inequity through no choice or action of the individual who is disadvantaged. The problem of such an approach is where one draws the line of limits whereby society can not, because of resource limits, make up for all unfortunate conditions.

It is important to note that Beauchamp and Childress endorse the egalitarian approach to justice with its incorporation of a fair opportunity rule but also outline further considerations when this theory is specially applied to distributive justice of health care resources when those resources are limited by several contemporary restraints of cost, equipment, and personnel among others.

With regard to the question of a minimal level of health care and a right to such care, Beauchamp and Childress argue that all do have a right to health care. The authors believe, first, health care is a part of a category of social protections that governments are created to provide albeit at some

¹¹ Beauchamp and Childress, 271.

minimum level. Second, societies are obligated to provide equal opportunity for all citizens. If ill health or other physical or mental disadvantages prevent such opportunity or equal access, then society, by the fair opportunity rule, must provide health services that compensate.

Libertarians (such as Engelhardt) argue against the obligatory language of such a position. This opposition does not deny the goal of egalitarian justice and would seek to convince a society that it is worthwhile but would draw the line at obligation until society itself has made and agreed to such a commitment. The tension between obligation and freedom is a key tension that exists in a covenantal ethic as well but one that is resolved in an understanding that freedom is truly found when one is tied to others in covenantal obligation.

If one follows the line of argument that Beauchamp and Childress present, then the next key step is the establishment of a minimum level of health care to which all have a right. The response of the authors is that the programmatic answer in terms of specific treatments to which one has a minimal right is not defined by moral theory but only by political process. What theory can do however, is to provide a framework in which priorities can be justly set within a just process.

There are two such processes at work in the distribution of health care resources -- macroallocation and microallocation. "Macroallocation decisions determine how much should be expended and what kinds of goods will be

made available in society, as well as how it is to be distributed."¹²

Microallocation refers to how health care professionals "decide which persons will receive some available but scarce medical resource that cannot be provided to everyone who needs it."¹³

Issues within the macroallocation arena include: how much of a society's budget it wishes to dedicate to health care; the categories of illness or injury treatments that will fall under approved expenses and the priority of such categories; and the determination of access and distribution of technology, equipment, and personnel resources. The principle of justice as defined through an egalitarian model can only raise the issues and guides to direct the process but the specific treatments and minimal levels to be provided are political questions for the appropriate institution of a society.

Microallocation decisions are, in large part, made in response to macroallocation boundaries or lack thereof. However, since many such decisions are made in response to specific patients, generalized rules are difficult to apply and may be in tension with a physician's own moral position. Therefore, the need is for some procedural guidelines to help in the decision making process much like those that had to be developed by the review committee for the renal dialysis program at the birth of bioethics.

¹²Beauchamp and Childress, 283.

¹³Beauchamp and Childress, 290.

Two procedural needs are defined by Beauchamp and Childress, "determining the relevant pool of recipients (for particular treatment) and procedures for the final selection of recipients."¹⁴ The application of the principle of justice is important in both of these processes. In consideration of the first process, determining the pool of recipients, the question of "morally relevant properties" is raised as one determines whom to include and whom to exclude. Justice requires that the properties truly be morally relevant and not just based on criteria open to bias. The prospect for success of a particular treatment is also an important consideration in morally determining the pool of recipients.¹⁵ The relative probability of success of a particular treatment for two patients is morally relevant if the treatment, because of limited resources, can not be offered to both patients. In such a situation the process of microallocation should determine that the treatment be given to the patient who will get the best net benefit. Such a conclusion might be called medical utility. There is also social utility. In social utility one evaluates patients' worth to society to determine which patient should receive a treatment. For example, it may be that one's lifestyle may mean that a particular treatment has little utility because the person's lifestyle will soon reverse the good of a treatment. This argument has been used to

¹⁴ Beauchamp and Childress, 292.

¹⁵ Beauchamp and Childress, 294.

advocate not giving liver transplants to alcoholics for example.¹⁶ The use of such criteria as social utility is controversial and full of temptations to bias. Social utility, nevertheless, does have its usefulness, especially when the social factors will determine the efficacy of a particular medical treatment.

Once the pool of potential recipients has been decided, often there is still a need to determine who in the pool will actually receive the limited resources of the treatment. Here again, medical and social utility may come into play along with other "chance" methods such as queuing or a lottery. Beauchamp and Childress conclude "that justice, in conjunction with other principles, mandates attention to medical utility followed by the use of chance and queuing for scarce resources when medical utility is roughly equal for eligible patients."¹⁷ Social utility is only used as a determinant in emergency situations and only after attending first to all of the factors under medical utility and chance determinations.

Beauchamp and Childress present no unified presentation of justice applicable within the changing landscape of resource allocation of health care. They do, however, raise important issues that are germane to a covenantal ethic approach. The tensions between autonomy and community,

¹⁶See Alvin Moss and Mark Siegler, "Should Alcoholics Compete Equally for Liver Transplantation?" Journal of the American Medical Association 265 (1991): 1295-98.

¹⁷Beauchamp and Childress, 301.

between beneficence and nonmaleficence, are particularly felt in decisions of justice. Responsibility is a concept that must be tested against multiple levels, all claiming priority. Covenantal ethics offers some unique perspectives which help in resolving some of the conflicts and in the application of justice.

Justice and Covenantal Ethics

In this section the task is to examine the concept of justice from the perspective of a covenantal theology and apply the revised understanding in covenantal ethics. Particular emphasis will be placed on the concept of justice as it relates to the allocation of scarce health care resources, which is the subject of the case study to follow.

Justice is Relationship

"The old ethics spoke to physicians about their actual patients. Justice in health care has no actual patients: it seeks a principle of distribution that will, in anticipation of actual need, count some persons as worthy of attention and count others as not."¹⁸ Jonsen laments the passing of the days when the physician could be like the Good Samaritan and respond out of compassion to heal the sick even at a cost to him/herself. In the days of the old medicine, as Jonsen sees them, it was possible to practice medicine this way. Now it seems to do so would be utterly impossible from the standpoint

¹⁸Jonsen, New Medicine and the Old Ethics, 44.

of both time and resources. Justice can no longer be applied by the same old rules.

Still the principle is held in high regard within American society and medical practice. To hold on to the principle within the contemporary framework, new theories have been advocated. Among them is the work of John Rawls¹⁹ in which he advocates a hypothetical, impartial group of persons "who make choices under conditions in which they are ignorant of personal relationships or social ties to one another."²⁰ The assumption in such a theory is that justice can only be served if it is done impartially and outside of the ties of relationship. Certainly, this is a foundation of American jurisprudence with its symbol of the blindfolded woman holding the scales of justice -- the image portraying the impartiality of justice that can only be maintained as it is blind to differences and therefore is able to practice the Aristotelian concept of equal treatment for equals. Covenantal theology disagrees with this approach on two levels, one theological and the other practical, while still maintaining a commitment to a basic egalitarian ethic.

Theologically, covenant *is* relationship and justice as a social concept can only be practiced within relationship. More, it is only in this covenantal

¹⁹ See John Rawls, A Theory of Justice (Boston: Belknap Press of Harvard University Press, 1971)

²⁰ Jecker and Berg summarize Rawls in Nancy S. Jecker and Alfred O. Berg, "Allocating Medical Resources in Rural America: Alternative Perceptions of Justice," Social Science and Medicine 34 (1992): 469.

relationship that one fully expresses the obligation to *do* justice. Certainly the model for this is the covenantal relationship of God to God's people in which justice is known not in the presence of an impartial God but rather, a God who is both compassionate and just and a God active in the history of the people with whom God is in relationship. God in relationship commits to the obligation of justice which, in turn, can only be experienced within the relationship's covenant. A covenantal theology definition of justice, then, would not insist on an impartial relationship but rather a relationship that obligates one to another and in which the true freedom of the relationship is known in the obligation to be tied to one another. It also insists that justice can not be impartial but even assumes an obligation to be partial on behalf of those least able to advocate for themselves -- thus, the theological difference with contemporary theory.

The practical difference with contemporary theory lies in the necessity for relationship to enrich the practice of justice. In a study of the practice of justice in rural health care, Jecker and Berg discovered that in rural medicine it is not possible to practice medicine or justice outside of the complex and intricate social relationships that exist inside and outside of the medical office.

Just as rural physicians construe problems of justice from the perspective of competing loyalties, not surprisingly the terms by which they negotiate solutions emphasize keeping social ties and relationships intact. Where scarce resources render beneficence towards neighbors difficult, the solution is not to take a bird's eye view, or restate ethical

problems in terms of property rights between disinterested parties. Rather, the vantage point from which distributive choices are made is the physician's position in a complex web of human relationships.²¹

This reality observed in the practice of medicine and allocation of resources in rural settings has lessons to offer for all allocation decisions and it fits within the framework of a covenantal ethic approach. These lessons include the ideas that contemporary practices of justice cannot be viewed from the impartiality of theory but only within the context of clinical decisions which involve commitments to relationships and therefore will, of necessity, balance all justice considerations with beneficence and with the competing obligations and loyalties that are a part of the medical practice. It also implies that the only way to set *standards* of justice for the design of a *system* of justice is to involve the community in which those standards are practiced and for whom the system is designed.

In the Oregon Plan of providing health care to all of its citizens, an effort was made to involve the state community in the process of expressing values on which allocation decisions would be made. There are some justifiable criticisms regarding the actual process of these community

²¹Jecker and Berg, 471.

hearings,²² but the goal is admirable and the process could and should be refined to make it better. What is important about the goal is, like the rural practice of medicine, it takes the values and the relationships of the community seriously and involves them in the setting of the foundation on which the system will be designed. This is a goal of a covenantal ethic of justice a well.

There is another advantage of community involvement in the defining of justice as it relates to health care decisions and that is it begins to set in place the responsibility of relationships and the obligations of relationships -- two important concepts to a covenantal ethic.

In a covenantal ethic, responsibility for others comes with the understanding of oneself as defined as a part of community.

(1) A covenant is a transaction of promises given and accepted; it is rooted in a prior sense of good as a potentiality of life discovered in the nature of existence and realizable in a new social relationship. (2) It confers the status (social identity) of being the member of a community, a person with definite freedoms or rights. (3) It also defines duties or obligations that become concrete in a given historical community; these

²²In his critique, Norman Daniels points out that the hearing groups mainly consisted of middle class, highly educated folks who came together to establish values that would design a system that would apply, not to them, but to the less well-off in the society. "Some 50% were health professionals; too many were college educated, white, and relatively well-off. Moreover, whereas 16% of Oregonians are uninsured, only 9.4% of community meeting participants were uninsured, and Medicaid recipients, the only direct representatives of poor children, were underrepresented by half." See Norman Daniels, "Is the Oregon Rationing Plan Fair?" Journal of the American Medical Association 265 (1991): 2234.

have a relative degree of openness to change through mutual
redecision.²³

Thus, self and community, freedom and obligation go together in the covenantal ethic. Such a covenantal community defines responsibility. For one to operate within such a community means that one is only one's self as one exercises one's responsibility toward others. Justice, in such a framework, requires relationship for it can only first be defined, and then performed, as one is in relationship with those who will form the definition and with whom one is obligated to do justice in relationship. In the practical world of health care ethics and particularly in the field of recourse allocation, this means a return to a true democratic way of making decisions and a change in the attitude of the public where, as Robert Bellah puts it, America can return to the covenant that it broke. Where liberty can regain its meaning of serving the public good and get away from its current understanding of acting only in one's own self interest.²⁴

The physician's role within this relationship as it relates to justice and resource allocation is not as the gatekeeper by default as is currently the case, but as a full participant in the value discussion first, then as an advocate for a responsible use of medical technology understanding and

²³George K. Beach, "Covenantal Ethics," in The Life of Choice: Some Liberal Religious Perspectives on Morality, ed. Clark Kucheman (Boston: Beacon Press, 1978), 113.

²⁴Bellah, 18.

advocating a covenantal value system that does not continue to practice the old ethic of medicine that everything that can be done should be done. One key to the physician's new role is in a radical understanding of who is the patient.

The Patient is a Population

Medical practice has focused on the patient as the person whom the physician is immediately treating. The Hippocratic tradition calls the physician to the focused loyalty to serve that patient and to use the full skill of the physician's art to do so. In reality, however, the physician serves a population of patients since the physician has to balance the amount of time and resources given to one patient knowing that there are other patients to be served in the waiting room. Still, the myth persists that a physician serves the patient. In part society has reinforced this myth by insisting that when one is in the immediate care of a physician one demands the full attention and the full resources of that physician. In the libertarian view of ethics this is as it should be. In today's practice, however, with limited resources it simply is not possible. The patient is not only the person who is in front of the physician to be treated but is a whole population of patients that can include, depending on the particular situation and issues, those patients in the waiting room, those in the whole of the physician's practice, those included in an HMO, and those in the entire population of the society's medical resource allocation system. To deal with the reality rather than the

myth requires the first step of realizing that the patient is a population and then finding ways ethically to respond to this. Because covenantal ethics requires responsibility to community in doing justice, it is uniquely well suited to answer the challenge.

There are two implications of this idea of the patient being the population. One, as referred to above, is for the physician; the other is for the individual patient who must see him or her self not just as the individual who demands and has a right to all of the resources possible, but who sees him or her self as a part of a community population with whom to share resources and who has a responsibility to make just decisions even if it means a sacrifice of the resource that one could get for themselves because the resources are needed more or can be used better by another person.

David Eddy, in a provocative article regarding resource allocation, paints a picture of a fictitious company and its employees making decisions about how they will cover their health care costs. The company serves as an analogy for the larger society of the United States, which is trying to do the same thing. Eddy rightly sees the conflict, as currently conceived, as individuals *against* society.²⁵ The challenge of finding a solution to the distribution of limited resources begins with redefining the conflict as individuals *in* society. The practical implication of this is that each

²⁵David M. Eddy, "The Individual vs Society: Resolving the Conflict," Journal of the American Medical Association 265 (1991): 2399-2406.

individual understands he/she is a part of a pool of resources which must be split on a fair share basis. To do so means a different understanding of equitable.

In health care, "equitable" cannot mean an equal amount of services. . . . In the context of health care, a preferable definition of *equitable* is that services should be used in such a way that the services received by each individual should provide them with approximately equal amounts of benefit per unit of resource consumed. . . . This definition has the desirable property that, if followed, it will use the available resources to yield the greatest total benefit.²⁶

Eddy goes on to illustrate, using his fictitious company, that such an equitable system is only accomplished through a new awareness of the others in the system and the willingness to see one's decisions regarding one's own health care as impacting the decisions that others make as well. Thus, patients do not see themselves as individuals who have the right to as much of the resources as they are able to afford and consume, but as a part of a community who have equal right to the resource based on the fact that they are a part of the same community that shares the resources. In other words, the patient is a population for the members of the community as well as for the physician who treats individual patients.

Covenantal theology sees the world as just such a population. "The great achievement of covenantal theology was to construct a theory of communal responsibility in which law and the good were united, in which

²⁶Eddy, 2399.

attainment of the good -- of blessing and prosperity -- was made conditional upon obedience to fundamental moral law."²⁷ Justice is such a moral law and, as has been illustrated, the beginning of its practice is understanding oneself in covenant community.

One objection to this idea of patient as population is that it may be construed as lowering the value of the individual. In rationing decisions it could be interpreted as violating "the cherished ideal that no member of society should be considered less worthy and less desirable than another."²⁸ This objection raises the question of where one obtains the value of the individual. It would be a mistake to assume that society is in any position to place a value on any individual's life. The value of an individual is not assigned by society nor should decisions about the allocation of medical resources be based on the supposed value of an individual *to* society. Rationing decisions should be made based, not on individual value, but on shared responsibility and the value of the total community. Therefore, when one makes a decision about allocating a resource to patient "A" and not to patient "B," one does so because through careful weighing of all of the factors involved (medical indications, patient preferences, quality of life, and all of

²⁷ E. Clinton Gardner, "Justice in the Puritan Covenantal Tradition," Journal of Law and Religion 6, no. 1 (1988): 47.

²⁸ Nancy S. Jecker and Lawrence J. Schneiderman, "Futility and Rationing," American Journal of Medicine 92 (1992): 195.

the contextual factors) the net benefit belongs to one patient over another, a net benefit for the balance of the patient and the community. Such a decision does not lessen the value of either patient, indeed does not say anything about the value of either patient as an individual human being. It is a decision based on equal justice in a model of covenantal community fidelity.

There are other implications of such an approach. Decisions regarding the level of care and the limits of the levels of care that can be provided are community decisions. This was spoken to above in regard to the Oregon Plan. There is another important implication of this concept, however, that should be brought up here. For this covenantal model to work will take a profound and fundamental attitudinal change within the society. How can this be accomplished? Within a totalitarian state one might just proclaim it so but in the United States this would not be possible nor is it necessary. The United States system of government has within it a principle of democracy that has as an important premise that private perspectives can be transformed into a public vision. Such a transformation is necessary for this society to recapture, as Bellah advocates, the covenant within the society. Such a transformation is a part of the dialogue that needs to take place as the definition of justice is worked out that will determine the allocation of health care resources. "[T]he task of civic education . . . will become . . . more creative and demanding. It will not be that of simply receiving and passing along the messages [community health decision groups] collect from the

public. Rather, their task will be to provide some structure for public discourse that transforms, and does not simply transmit, moral reflection and civic deliberation on the ends of health care in our communities."²⁹ Such a transformation will be necessary if health care allocation decisions can be made with a vision that rises above one's own self interest to see the interests of the total community of the society.

Only when this can take place will true distributive justice be known and practiced: a distributive justice that enables the Good Samaritan physician to be just³⁰ and the less well off in society to receive the covenantal care to which the rest of the society is obligated. As it is now within distributive justice, the needs of the poor seem to conflict with the distribution of medical resources to all. However, if the patient is the population, then the distribution of medical resources to the poor is no conflict but a necessary condition for distribution *to be* just.

Rationing

Distributive justice assumes some kind of rationing. This is not a universally accepted conclusion although it is becoming more widely so given the rise in costs and the lack of health coverage for so many. Earlier the reality of soft rationing was shown to be a part of medicine that has been

²⁹ Bruce Jennings, "Democracy and Justice in Health Policy," Hastings Center Report, September/October 1990, 23.

³⁰ Jonsen, New Medicine and the Old Ethic, 59.

practiced for a long time. It seems to this study that the time has come to recognize that some form of *hard* rationing is a necessary part of distributive justice in the decades ahead. Callahan agrees:

Rationing will be (is) necessary to attain a goal of universal access to decent care. A system cannot promise to pay for every technological advance; cannot promise to help all of us live as long as we choose; cannot promise to jeopardize other important societal needs in pursuit of improved health.³¹

Further, says Callahan, current cost containment efforts will not do the job soon enough. Therefore, rationing as an option will have to be considered.

Concern must focus, then, not so much on *if* society will have a rationing plan for allocating health care resources but *how* will one be developed and *what* will its major components be. One aspect of the how question has been addressed in the need for a modified Oregon Plan community hearing process. For the what one might begin with the basic features that are a part of most distributive justice theories. Common features are:

1. All are concerned with what people are entitled to (deserve),
2. All make a distinction between justice on the one hand and charity on the other, or, what is required to do and what we would like to do, and,
3. All relate freedom to equality. The more emphasis is put on equality the more restrictions there are placed on freedom and visa versa.³²

³¹Daniel Callahan, "Symbols, Rationality and Justice," American Journal of Law and Medicine 18, nos. 1-2 (1992): 5.

³²Nancy S. Jecker, "Health Professional's Ethical Role."

Theories of distributive justice then, advocate different answers to each of these concerns as they try to define what a rationing plan would look like based on these answers.

The covenantal ethics approach, as described here, responds to each of these features of distributive justice in a unique way:

1. People are entitled to what the covenantal community determines as just. This is not based on what one can afford but rather is a truly egalitarian system that is voluntarily agreed to. It comes from a deep attitudinal change and conviction that all are a part of the body and therefore all are worthy of care.

2. Justice *is* what we are required to do. Charity in a covenantal ethic does not have the same meaning as in other theories of distributive justice. Justice includes what other theories only include in charity. Because justice includes the *obligation* to the less well off in the community, charity is carried out through justice.

3. Freedom in covenantal ethics *is* obligation. These two are not inversely related as in most theories of distributive justice. In a covenantal ethic one truly discovers freedom as one is in a covenantal bond with another. Obligations are not burdens, in such a scheme of things, but are part of the joy of being interrelated in the bond of responsibility.

Such a theory of distributive justice within covenantal ethics makes rationing not a burden but an expression of the relationships that shape our identity and our self worth as well as the worth of the community.

A Case Study -- Kenny G.³³

The Case

Kenny G. was referred to the rehabilitation medicine clinic for a mobility and communication evaluation. He was evaluated in the clinic by the attending physician, the physical and occupational therapists, a communication disorders specialist and a fourth year medical student.

Kenny was a 3-year-old boy with a diagnosis of cerebral palsy of primarily athetoid type. His past medical history revealed that he was the product of a pregnancy for which there was no prenatal care. He was delivered at home, and only sought medical attention at 72 hours of age when he presented to the emergency room lethargic and jaundiced. Laboratory evaluation was significant for hemolytic anemia, Rh incompatibility and a serum unconjugated bilirubin of 34 mg/100ml. He had one seizure soon after admission and underwent emergency exchange transfusion. He had a stormy neonatal course but was discharged to home at 40 days of age.

³³This case, presented by Ross M. Hays, M.D., is contained in the manual of the 4th Annual Summer Seminar in Health Care Ethics held at the University of Washington Medical School, August 5-10, 1991. As presented here the case has been edited for space and application to this study.

Kenny was enrolled into an early intervention program for high risk infants. Kenny was attentive and alert but completely non-verbal; he could indicate his needs to his family by responding to questions with repetitive gestures. Using this technique he could match colors and some letters. He was tested in the developmental center and felt to have appropriate receptive language skills for a 5-year-old. Although he was severely limited in his motor control, his language scores suggested that his cognitive skills were at least at the expected range for a 3-year-old and perhaps even higher.

When Kenny's mother discovered he was able to purposefully select the correct television channel for Seasame Street by operating the remote control device with his right thumb, she began to question whether he might be able to use a computer-assisted augmentative communication device or a motorized wheelchair. His local therapist tried a number of switch interfaces but could not identify a reliable mechanism by which Kenny could operate any equipment. She referred Kenny to the pediatric rehabilitation clinic for a more thorough evaluation. In the clinic he demonstrated the ability to drive a motorized wheelchair.

Kenny could not suppress his delight at being able to move for the first time in his life. He began to laugh uncontrollably. He was so successful with the wheelchair that the same interface was transferred to an augmented communication device. After twenty minutes of training with the occupational therapist he was able to combine two symbols on the keyboard,

prompting the device to electronically speak the phrase "Hi, Mom!" Kenny had effectively taken his first steps and spoken his first words within the same hour in the rehabilitation clinic.

The physician began the process of prescribing the necessary durable equipment. The combination of the wheelchair, augmentative communication device and the computer interface would cost approximately \$34,000. Although the family had some income, they qualified for state assistance. It was anticipated that the state-administered Medicaid program would fund this equipment prescription.

The medical student took the physician aside to make the following comment: "I can't believe you are going to authorize a \$34,000 wheelchair for this 3-year-old. I see patients at the City Clinic where we can't even afford a part-time lab tech. We frequently treat sexually transmitted diseases on the basis of gram stains done by second-year med students! You could spend \$34,000 in a needle exchange program and prevent AIDS for hundreds of people. I could use that money to pilot a prenatal project at the City Clinic and prevent a whole lot of babies ending up like this kid. At least wait until this kid is old enough to go to school; if you give him this stuff now, you're just going to have to replace it when he gets older."

Commentary

There are several issues that present themselves in this case. As one applies covenantal ethics to cases of distributive justice a constant tension will be the realities of the current systems of providing health care resources which limit the true implementation of a covenantal ethic. Therefore, the challenge is to apply what can be applied of covenantal ethics within the current health care system while working toward a more just system built on the covenantal model.

The issue of prevention vs. treatment is the one presented by the medical student. Current literature (Eddy, Raanan Gillon) is inconclusive regarding the net dollar value gained by prevention over treatment. Certainly, in the case of prenatal care that the medical student cites, it would seem that prevention is in fact cost effective in preventing some birth defects that, if not prevented, would cost far more to treat than to prevent. But is this an appropriate question to raise in regard to a particular clinical decision as in this case? The answer to that is found in the next issue raised.

The issue of the "closed" vs. "open" system addresses the question regarding the effect of not spending some resources for one patient to enable them to be spent for another patient. In a closed system this kind of transfer of funds may be possible. Decisions would have to have been made at some policy level or, at the very least at a clinic or HMO level, in order for funds not spent in one place to be directly moved to another place and used. The

health care system in the United States, as it currently exists, is not a closed system. If, for example, the \$34,000 in the above case were not spent on the wheelchair there is no mechanism for the dollars to be moved to the medical student's City Clinic for prevention. Thus, although the argument is persuasive in terms of efficacy of dollars spent, within the current constraints of health care delivery the argument does not hold up.

This issue does point out the need for a system-wide agreed upon prioritizing of medical expenses. It is the only way to ask the question of equal share in regards to Kenny. Without some system-wide way to evaluate and establish priorities there is no way equal share can be used to prevent Kenny from getting the wheel chair. Without a closed system there is also no way to argue that the dollars should not be spent so that they could be used for prevention. Are there any alternatives then to address the concerns raised by the medical student?

The issue of microallocation and macroallocation highlights the dynamics of making a decision for one patient based on motivations that are directed toward serving many patients. The medical student asks for just such a decision. Indeed, it is the kind of soft rationing decision that is often made in medical practice. The only difference may be the amount of dollars that is involved. Microallocation decisions can only be made on the basis of the physician's relationship with the patient and his/her best judgment regarding the efficacy of a particular treatment. In the case of Kenny, the

efficacy of the wheelchair has been demonstrated and, although the objection that he would outgrow the wheelchair is valid, the wheelchair and/or its parts could be used for another patient after Kenny outgrew it. For the physician to make a judgment in this case she/he would have to determine the probability of success of the wheelchair to accomplish the sought-after medical goals. This is the only kind of rationing question that the physician can morally raise within the current system of health care resource distribution. If the state allocation of Medicaid had said that this wheelchair could not be afforded, then this is a macroallocation decision that would put a justifiable constraint on the physician writing the prescription. (Whether it would be a just constraint is another issue altogether.) Since this is not the case, the physician does have an obligation to this patient that would justify the writing of the prescription. Are there any moral principles that would support the physician's decision?

The balance of beneficence and nonmaleficence will help address this question. One way of looking at these two principles is that beneficence means to make things better while nonmaleficence means to not make things worse. In Kenny's case it is apparent that to not provide the wheelchair would not make things worse for him while providing the wheelchair would make things better. Which principle would be given more weight in this case? Looking at just these two principles, it would be impossible to weight one over the other. Therefore, other principles and

contextual factors will have to provide the weight that will tip the scales one way or the other. In this case the state is willing to pay the bill, the family seems willing to provide continued support, medical indications have shown that the wheelchair accomplishes several medical goals, and Kenny himself seems to derive much benefit from his own perspective. All of these factors, then, would weight the principle of beneficence higher than nonmaleficence and, thus, the chair should be provided.

A different scenario might be played out if Kenny were a part of a clinic where there was a limited amount of resources to provide for wheelchairs and there was no room to move resources from one treatment to another. In such a case *justice* and beneficence must take into consideration the population of patients of which Kenny is a part. Covenantal ethics at that point asks the question of responsibility of Kenny and of all of the patient's in the group. (Again, in actual practice, these decisions would have already been reached in policies defining how resources will be divided and these policies would have been agreed to by all of those within the group.) It may be, in such a revision of the case, that Kenny would wait to receive the wheelchair until resources could be freed up. Since his case is not a life-threatening one, resources should not be shifted from one treatment need to his. Such decisions would have to be made based on the agreed-upon values for distribution of resources and the understanding of the covenants that bind the group as a community.

Conclusion

This case within the microallocation decision seems fairly clear. The more complicated issues are brought in to play when the macroallocation decision must be faced. As this case points out, the clinician can not be asked to make macroallocation decisions that society has not made. The physician can not be the gatekeeper for society unless society tells the gatekeeper when to open and when to close the gate. Thus there is a need to form a just system of health care resource allocation. The covenantal ethic discussed here provides some important guidelines as to how that macroallocation decision can be made.

Bibliography

Autonomy

- Brooks, Dan W. "Paternalism and Autonomy." Ethics 98 (April 1988): 550-65.
- Cahill, Lisa Sowle. "Abortion, Autonomy and Community." In Abortion and Catholicism: The American Debate. Eds. Patricia Beattie Jung and Thomas A. Shannon. New York: Crossroad Publishing, 1988.
- Callahan, Daniel. "Autonomy: A Moral Good, Not a Moral Obsession." Hastings Center Report, October 1984, 40-42.
- Cassell, Eric J. "Life as a Work of Art." Hastings Center Report, October 1984, 35-37.
- Childress, James F. "The Place of Autonomy in Bioethics." Hastings Center Report, January/February 1990, 12-17.
- Crigger, Bette-Jane, ed., Cases in Bioethics: Selections from the Hastings Center Report. 2nd ed. New York: St. Martin's Press, 1993.
- Feinberg, Joel. Harm to Self. New York: Oxford University Press, 1986.
- Gustafson, James M. "Agency and an Interactional Model of Society." In On Moral Medicine: Theological Perspectives in Medical Ethics. Eds. Stephen E. Lammers and Allen Verhey. Grand Rapids: Eerdmans Publishing, 1987.
- Richards, David A. J. "Rights and Autonomy." Ethics, October 1981, 3-20.
- Veatch, Robert M. "Autonomy's Temporary Triumph." Hastings Center Report, October 1984, 38-40.

Biomedical Ethics

- Beauchamp, Tom L. Philosophical Ethics. 2nd ed. New York: McGraw-Hill, 1991.
- Beauchamp, Tom L., and James F. Childress. Principles of Biomedical Ethics. 3rd ed. New York: Oxford University Press, 1989.

- Blake, David C. "The Hospital Ethics Committee: Health Care's Moral Conscience or White Elephant?" Hastings Center Report, January/February 1992, 6-11.
- Jecker, Nancy S. "The Contribution of Philosophical Ethics." Paper delivered at the 4th Annual Summer Seminar in Health Care Ethics. University of Washington Medical School, Seattle. 5 August 1991.
- Jonsen, Albert R. "Ethics and Clinical Decisions." Paper delivered at the 4th Annual Summer Seminar in Health Care Ethics. University of Washington Medical School, Seattle. 5 August 1991.
- . "How the New Medical Ethics Came to Be." Paper delivered at the 4th Annual Summer Seminar in Health Care Ethics. University of Washington Medical School, Seattle. 5 August 1991.
- . "Introduction to Medical Ethics." Presentation Outline from the 4th Annual Summer Seminar in Health Care Ethics. 5-10 August 1993, University of Washington Medical School, Seattle.
- . The New Medicine and the Old Ethics. Cambridge: Harvard University Press, 1990.
- Jonsen, Albert R., Mark Siegler, and William J. Winslade. Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine. 2nd ed. New York: Macmillan, 1986.
- Lammers, Stephen E., and Allen Verhey, eds. On Moral Medicine: Theological Perspectives in Medical Ethics. Grand Rapids: Eerdmans Publishing, 1987.
- Mori, Maurizio. "The Philosophical Basis of Medical Ethics." Social Science and Medicine 25 (1987): 631-36.
- Murray, Thomas H. "Medical Ethics, Moral Philosophy and Moral Tradition." Social Science and Medicine 25 (1987): 637-44.
- Nelson, James B., and JoAnne Smith Rohricht. Human Medicine: Ethical Perspectives on Today's New Medical Issues. Minneapolis: Augsburg Publishing, 1984.

Verhey, Allen. "The Doctor's Oath--and a Christian Swearing It." In On Moral Medicine: Theological Perspectives in Medical Ethics. Eds. Stephen E. Lammers and Allen Verhey. Grand Rapids: Eerdmans Publishing, 1987.

Covenantal Theology

Ashley, Benedict M. Theologies of the Body: Humanist and Christian. Braintree, Mass.: Pope John Center, 1985.

Beach, George K. "Covenantal Ethics." In The Life of Choice: Some Liberal Religious Perspectives on Morality. Ed. Clark Kucheman. Boston: Beacon Press, 1978.

Bellah, Robert N. The Broken Covenant: American Civil Religion in Time of Trial. New York: Seabury Press, 1975.

Kilner, John F. "A Pauline Approach to Ethical Decision Making." Interpretation 43 (October 1989) 366-79.

Kliever, Lonnie. H. Richard Niebuhr. Makers of the Modern Theological Mind. Waco: Word Books, 1977.

Lovin, Robin W. "Equality and Covenant Theology." Journal of Law and Religion 2 (1984): 241-262.

Moltmann, Jürgen. God in Creation: An Ecological Doctrine of Creation. Gifford Lectures, 1984-85. London: SCM Press, 1985.

Nelson, James B. Body Theology. Louisville: Westminster/John Knox Press, 1992.

---. Embodiment: An Approach to Sexuality and Christian Theology. Minneapolis: Augsburg Publishing, 1978.

---. Moral Nexus: Ethics of Christian Identity and Community. Philadelphia: Westminster Press, 1971.

Niebuhr, H. Richard. Christ and Culture. New York: Harper & Row, 1951.

---. "The Idea of Covenant and American Democracy." Church History 23 (June 1954): 131-35.

- Niebuhr, H. Richard. The Kingdom of God in America. Chicago: Willett, Clark & Co., 1937.
- . The Meaning of Revelation. New York: Macmillian Co., 1941.
- . Radical Monotheism and Western Culture. New York: Harper, 1960.
- . The Responsible Self. New York: Harper & Row, 1963.
- . "The Responsibility of the Church for Society." In The Gospel, the Church and the World. Ed. Kenneth Scott Latourette. New York: Harper & Bros. 1946.
- Ramsey, Paul. Preface to "The Patient as Person." In On Moral Medicine: Theological Perspectives in Medical Ethics. Eds. Stephen E. Lammers and Allen Verhey. Grand Rapids: Eerdmans Publishing, 1987.
- Whitehead, Alfred North. Process and Reality: An Essay in Cosmology. Corr. ed. Eds. David Ray Griffin and Donald W. Sherburne. New York: Free Press, 1978.

Euthanasia

- Coleman, Gerald D. "Assisted Suicide: An Ethical Perspective." Issues in Law and Medicine 3 (Winter 1987): 267-79.
- Dickey, Nancy. "Commentary." In Cases in Bioethics: Selections from the Hastings Center Report. 2nd ed. Ed. Bette-Jane Crigger. New York: St. Martin's Press, 1993.
- Engelhardt, H. Tristram Jr. "Commentary." In Cases in Bioethics: Selections from the Hastings Center Report. 2nd ed. Ed. Bette-Jane Crigger. New York: St. Martin's Press, 1993.
- Holbrook, David. "Medical Ethics and the Potentialities of the Living Being." British Medical Journal 291 (1985): 457-63.
- Kamisar, Yale. "Are Laws Against Assisted Suicide Unconstitutional?" Hastings Center Report, May/June 1993, 32-41.
- Vaux, Kenneth L. Death Ethics: Religious and Cultural Values in Prolonging and Ending Life. Philadelphia: Trinity Press Intl., 1992.

Vaux, Kenneth L. "The Theologic Ethics of Euthanasia." Hastings Center Report, January/February 1989, 19-22.

Veatch, Robert M. Death, Dying, and the Biological Revolution. New Haven: Yale University Press, 1976.

White, Robert B. "Comentary." In Cases in Bioethics: Selections from the Hastings Center Report. 2nd ed. Ed. Bette-Jane Crigger. New York: St. Martin's Press, 1993.

Young, Ernle. "Assisting Suicide: An Ethical Perspective." Issues in Law and Medicine 3 (1987): 281-93.

Health Care Resource Rationing and Justice

Callahan, Daniel. "Symbols, Rationality and Justice." American Journal of Law and Medicine 18, nos. 1- 2 (1992): 1-13.

Daniels, Norman. "Is the Oregon Rationing Plan Fair?" Journal of the American Medical Association 265 (1991): 2232-35.

Eddy, David M. "The Individual vs Society: Resolving the Conflict." Journal of the American Medical Association 265 (1991): 2399-2406.

Gardner, E. Clinton. "Justice in the Puritan Covenantal Tradition." Journal of Law and Religion 6, no. 1 (1988): 39-60.

Hays, Ross M. "A Case Study - Kenny G." TS. 4th Annual Summer Seminar in Health Care Ethics. University of Washington Medical School, Seattle. 9 August 1991.

Jecker, Nancy S. "The Health Professional's Ethical Role in Allocating Scarce Medical Resources." Paper delivered at the 4th Annual Summer Seminar in Health Care Ethics. University of Washington Medical School, Seattle. 9 August 1991.

Jecker, Nancy S., and Alfred O. Berg. "Allocating Medical Resources in Rural America: Alternative Perceptions of Justice." Social Science and Medicine 34 (1992): 467-74.

Jecker, Nancy S. , and Lawrence J. Schneiderman. "Futility and Rationing." American Journal of Medicine 92 (1992): 189-96.

Jennings, Bruce. "Democracy and Justice in Health Policy." Hastings Center Report, September/October 1990, 22-23.

Moss, Alvin H., and Mark Siegler. "Should Alcoholics Compete Equally for Liver Transplantation?" Journal of the American Medical Association 265 (1991): 1295-98.

Rawls, John. A Theory of Justice. Boston: Belknap Press of Harvard University Press, 1971.

Medical Indications, Futility and Beneficence

Callahan, Daniel. "Medical Futility, Medical Necessity: The Problem-Without-A-Name." Hastings Center Report, July/August 1991, 30-35.

Capron, Alexander Morgan. "In Re Hilga Wanglie." Hastings Center Report, September/October 1991, 26-28.

"Council on Ethical and Judicial Affairs of the AMA: Guidelines for the Appropriate Use of Do-Not-Resuscitate Orders." Journal of the American Medical Association 265 (1991): 1868-71.

Jecker, Nancy S., and Robert A. Pearlman. "Medical Futility, Who Decides?" Archives of Internal Medicine 152 (1992): 1140-44.

Orentlicher, David. "The Illusion of Patient Choice in End-of-Life Decisions." Journal of the American Medical Association 267 (1992): 2101-04.

"Position of the American Dietetic Association: Issues in Feeding the Terminally Ill Adult." Journal of the American Dietetic Association. 92 (1992): 996-1005.

Schneiderman, Lawrence J., and Nancy Jecker. "Futility in Practice." Archives of Internal Medicine 153 (1993): 437-41.

Schneiderman, Lawrence J., Nancy S. Jecker, and Albert R. Jonsen. "Medical Futility: Its Meaning and Ethical Implications." Annals of Internal Medicine 15 (1990): 949-54.

Truog, Robert D., Allan S. Brett, and Joel Frader. "The Problem of Futility." New England Journal of Medicine 326 (1992): 1560-64.

Veatch, Robert M., and Carol Mason Spicer. "Medically Futile Care: The Role of the Physician in Setting Limits." American Journal of Law and Medicine 18, nos. 1-2 (1992): 15-36.

Quality of Life and Maleficence

Arkes, Hadley. "Autonomy and the Quality of Life: The Dismantling of Moral Terms." Issues in Law and Medicine, May 1987, 421-33.

Arras, John D. "Toward an Ethic of Ambiguity." Hastings Center Report, April 1984, 25-33.

Braithwaite, Susan, and David C. Thomasma. "New Guidelines on Foregoing Life-Sustaining Treatment in Incompetent Patients: An Anti-Cruelty Policy." Annals of Internal Medicine 104 (1986): 711-15.

Goldworth, Amnon, and David K. Stevenson. "The Real Challenge of 'Baby Doe': Considering the Sanctity and Quality of Life." Clinical Pediatrics 28 (1989): 119-22.

Kaplan, Robert M. and Theodore G. Ganiats. "To the Editor re QALYs Their Ethical Implications." Journal of the American Medical Association 264 (1990): 2502-03.

La Puma, John, and Edward F. Lawlor. "Quality-Adjusted Life-Years: Ethical Implications for Physicians and Policymakers." Journal of the American Medical Association 263 (1990): 2917-21.

Nord, Erik. "Methods for Quality Adjustment of Life Years." Social Science and Medicine 34 (1992): 559-69.

Ramsey, Paul. Ethics at the Edges of Life: Medical and Legal Intersections. New Haven: Yale University Press, 1978.

Uhlmann, Richard F., and Robert A. Pearlman. "Perceived Quality of Life and Preferences for Life-Sustaining Treatment in Older Adults." Archives of Internal Medicine 151 (1991): 495-97.